Significant Decisions

of 2001 in

California Workers' Compensation

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OUTLINE FOR
2001 SIGNIFICANT CASE DECISIONS
IN
CALIFORNIA WORKERS' COMPENSATION

TABLE OF CASES

SIGNIFICANT CASE DECISIONS IN CALIFORNIA WORKERS' COMPENSATION IN 2001

I Jurisdiction

1. *Gunnell v. Metrocolor Laboratories, Inc.* (2001) 66 CCC 1308.

Three employees filed civil lawsuits against their employer for personal injury damages, contending that the tortious conduct of the employer caused them brain damage as well as other injuries and losses. Summary judgment was granted against two of the employees and the third was allowed to proceed to determine if the employer's conduct amounted to battery or willful physical assault which would have the effect of depriving the employer of his claim that the exclusive remedy is in the Workers' Compensation forum, not in the civil forum.

At trial the employee testified that he was an unskilled laborer who worked out of a union hall for the movie and film industry. He was employed by a film processing facility over a period of four and one-half months in 1989. The employer instructed him to use a blue-green soap to clean the interior of the facility. He was not told the name of the substance. The employer removed the labels from the containers to conceal the identify of the substance. The employer assured the employees that the substance was safe to use. The employees used the substance liberally, thinking it was soap. They were soaked with the substance on a daily basis because the employer gave them no protective clothing to wear and gave them no instruction as to its proper use. The employees become ill. They later learned that the cleaning substance was toxic to the brain and nervous system and any contact with the skin was to be avoided.

The jury returned a special verdict that the employer specifically intended to injure the worker; that the worker did not consent to being touched by the toxic chemical; that contact with the chemical caused injury to the worker; that the employer's conduct was a willful physical assault; and that the employer was guilty of oppression, malice, and fraud. The jury awarded damages, including punitive damages. The trial judge granted the employer's motion for judgment notwithstanding the verdict concluding that the employer was entitled to immunity from damages liability because Workers' Compensation was the exclusive remedy. The worker appealed.

The appeals court relied upon the case of *Johns-Manville Products Corp. v. Superior Court (Rudkin*) (1980) 45 CCC 704, to uphold the trial judge in precluding damages liability. The court rejected the applicability of exceptions to exclusivity raised by the worker, including the exception set forth in L.C. §3602(b)(1) for willful physical assault by the employer. Under *Rudkin* an injury

is within the course of employment even if caused by the employers deceit and concealment of hazardous substances used; failure to train the employee, and failure to assure a safe work environment. The employee and employer remain bound by the "compensation bargain" under which the employer assumes liability for industrial personal injury or death without regard to fault, in exchange for limitation or the amount of that liability. The employee, not having to prove fault, receives swift and certain benefits and in exchange gives up potential civil tort damages. The court cited L.C. §3602.

As to the worker's claim of battery the court relied on Penal Code §242 which says a battery is any willful and unlawful use of force or violence upon the person of another. Here the employee proved neither force, nor violence, so there is no battery.

As to the worker's claim of an exception under L.C. §3602(b)(1) which provides that willful physical assault by the employer does not come under the "compensation bargain", the court said this requires the same element as battery, that being use of force or violence. Since there was no proven use of force or violence, then L.C. §3602(b)(1) is inapplicable to the facts in this case. The court pointed out that the worker may have available the remedy of serious and willful misconduct of the employer under L.C. §4553.

The court awarded costs on appeal to the employer.

2. *Hughes v. Argonaut Insurance Company* (2001) 66 CCC 454, 29 CWCR 112.

The applicant was injured in a work-related traffic accident where there was no employer negligence involved. She received $5324.07 in workers' compensation benefits. With the help of her lawyer, she obtained a third-party settlement of $12,104.75. The settlement check was payable jointly to the employee, the employer, and the workers' compensation insurance company. The workers' compensation insurance company refused to endorse the check because to do so required it to reduce its lien by one third in order to pay attorneys fees to the employee's attorney for effecting the recovery. The employee then sued the carrier for bad faith, but the suit was dropped after the carrier agreed to endorse the check for a 2/3 recovery, with the balance being placed in trust pending a determination of the attorney fee issue. The plaintiff/employee attempted to proceed in Superior Court for the determination of the fee issue. The Superior Court dismissed the claim on the basis that it did not have subject matter jurisdiction and that exclusive jurisdiction is with the WCAB. The plaintiff appealed.

On appeal the court held that an employee whose on-the-job injury is caused by the legal fault of a third party is entitled to both workers' compensation benefits and to personal injury damages from the third party. The fault-free employer is

entitled to be reimbursed for benefits paid from the third-party settlement. Under Labor Code §3860(c), when settlement is effected solely through the efforts of the employee's attorney, then the employer's recovery must be reduced to pay a reasonable fee for the attorney's efforts in recovering the settlement.

Under L. C. §3860(f), the amount by which the insurer's recovery is to be reduced is to be set by the WCAB. The fee may be set by a superior court only when the recovery is obtained on settlement of a suit, or on any settlement requiring court approval. Here, the third-party settlement occurred before the filing of a suit, and no court approval of the settlement was required.

As to the exclusive jurisdiction of the WCAB, the court pointed to Labor Code §5300, which provides that proceedings for the recovery of compensation, or concerning any right or liability arising out of or incidental thereto, shall be instituted before the WCAB and not elsewhere. The Court saw no reason here to preempt the WCAB's exclusive jurisdiction.

3. *Lenk v. Total-Western, Inc.* (2001) 66 CCC 711.

Plaintiff had been a purchasing agent for ARB for six years. In 1996, defendant Total Western, Inc., approached him and allegedly made representations concerning profitability, promotional opportunities, and its financial condition. Relying on these representations, Lenk left ARB for "at will" employment at Total Western, Inc. After six months, Lenk and several co-workers were laid off due to loss of a large construction contract and business conditions.

Lenk sued Total Western, Inc., for breach of contract, fraud, and misrepresentation, and won a jury verdict for damages of $50,000 for emotional distress. On appeal defendant contended that the exclusive remedy for emotional distress damages suffered by an employee was under the workers' compensation law.

The Court of Appeal distinguished fraud in inducement to accept employment from injury in the course of employment. It held that defendant stepped outside of its proper role of an employer in misrepresenting its financial stability to induce plaintiff to accept its offer of employment. Therefore, it held the exclusive remedy of workers' compensation does not apply in these circumstances.

4. *Shingle Springs Band of Miwok Indians v. WCAB (Ivester)* (2001) 66 CCC 1283.

Certified for non-publication.

The applicant was injured while an employee of a health clinic operated by the Miwok Indians. The clinic was not on tribal lands, and the worker was not a member of the tribe. The applicant brought a claim before the WCAB. The Miwok Tribe claimed they were entitled to sovereign immunity and, therefore the

WCAB lacked jurisdiction to hear and decide the matter. The WCAB rejected the tribes assertion of sovereign immunity, finding that the applicant was not a member of the tribe, the injury did not occur on tribal land and that a claim of sovereign immunity from a claim of industrial injury has no relationship to tribal self government or to control of internal relations. The tribe petitioned for writ of review which was granted.

The appeals court annulled the WCAB decision, relying on the case of *Kiowa Tribe of Oklahoma v. Manufacturing Tech. Inc.* (1998) 523US751, which held that the doctrine of tribal sovereign immunity extends beyond the geographical borders of a tribe's reservation and covers commercial activities with persons who are not members of the tribe. As a matter of federal law an Indian tribe is subject to suit only where Congress has authorized the suit or the tribe has waived its immunity.

The appeals court, therefore, annulled the finding of jurisdiction and remanded the matter back to the WCAB to exercise its discretion under L.C. §5906 to take additional evidence with respect to the issue of whether the tribe waived their sovereign immunity in this case.

5. *Tucci v. Club Mediteranee, S.A.* (2001) 66 CCC 605.

Tucci, a California resident, accepted an offer for four months of employment at Club Med, Punta Cana, Dominican Republic. Tucci sustained an eye injury in the course of employment in the Dominican Republic. While eroute from treatment for the eye injury in a vehicle owned by her employer and driven by a co-employee, she sustained injury to her pelvis. Club Med in the Dominican Republic was insured as to workers' compensation liability by a French insurer, AXA Courtage, not authorized to write compensation insurance in California. AXA Courtage provided compensation and treatment benefits in excess of $110,000 to Tucci. The case report states that other benefits had been tendered by AXA Courtage but rejected by applicant.

Tucci filed a claim for workers' compensation benefits and a civil lawsuit for injury damages for Club Med's failure to secure payment of compensation under the California workers compensation law, and for negligent operation, maintenance and entrustment of the vehicle in which she sustained the pelvis injury.

Both plaintiff and defendants moved for summary judgment. Plaintiff alleged she was entitled to summary judgment for defendant Club Med's failure to secure payment of compensation under California law, and is therefore exempted from the exclusive remedy doctrine and entitled to a presumption of employer negligence. (L. C. §§3706, 3700(a).) Defendants contended that choice of law principles required application of Dominican Republic law, which provided workers' compensation and social security as exclusive remedies for plaintiff's injuries. The trial court noted that while Club Med did not have a California policy, AXA Courtage's coverage provided Tucci proper coverage under Dominican law. It

noted that no deficiency in appropriate benefits had been demonstrated by plaintiff. Where the injury occurred in the Dominican Republic and the employer had secured payment of compensation providing treatment and other benefits under the law of the situs of injury, and no defect in the compensation furnished was cited by plaintiff, the trial court held that the failure to secure a California approved compensation insurance policy did not warrant allowing applicant to sue for civil damages in California. Defendants' summary judgment motion was granted.

Plaintiff appealed from the summary judgment. The Court of Appeal noted that the issue was not of California jurisdiction under L. C. §5305, but of choice of law principles. California has jurisdiction under L. C. §5305 and *Travelers Ins. Co. v. Workers' Compensation Appeals Board*, (1967) 68 Cal. 2d. 7. Jurisdiction lies with the Workers' Compensation Appeals Board. Defendant, Club Med did not contest jurisdiction over it in the civil case at bar. Almost every state's workers' compensation law contains an exclusive remedy provision applicable where the employer secures payment of compensation for injury in the course of employment in the jurisdiction, and conversely there is an exception applicable where the employer fails to secure payment of compensation as required by the jurisdiction's laws. Under California law, employers in the state are required to secure payment of compensation by insurance or permissible self insurance, and if by insurance, their insurance must be by one or more insurers duly authorized to write compensation insurance in the state. Dominican Republic law provides the exclusive remedy for an employee injured there by workers' compensation insurance coverage which provides benefits irrespective of fault, and pension and health benefits provided by the Dominican Republic Social Security System. Where the employer meets the obligation to provide the workers' compensation insurance required by Dominican Republic law, an employee is barred from filing a civil action for negligence against the employer for work injury. A party advocating application of another state's law "must demonstrate that the rule will further the interest of that foreign state and that it is an appropriate one for the forum to apply to the case before it." The governmental interest analysis involves three steps: (1) is the foreign law consistent with that of the forum; (2) if there is a difference, which jurisdiction has an interest in application of its law; and (3) if there is a true conflict, the court must evaluate the comparative impairment of the jurisdictions.

Applying the test to this matter, the Court noted that the laws are inconsistent. California requires an insurer licensed to issue workers' compensation insurance in California; Dominican law does not. Each jurisdiction has an interest in applying its own law. Under the facts of this case, however, the Court concluded that the competing interests do not justify applying California law to enable plaintiff to seek additional recovery in tort. Applying California law here, to provide plaintiff a common law remedy, would contravene the quid pro quo around which American workers' compensation systems are designed, and would defeat the Dominican Republic's policy of providing limited and predictable legal liability. Tucci is

limited to receiving all workers' compensation benefits she is entitled to under the laws of both the Dominican Republic and of California. The summary judgement for defendants was affirmed.

II Employment

1. *Alfaro v. Workers' Compensation Appeals Board (Mier)* (2001) 66 CCC 1 (not published).

Employment was placed in issue in the case of an illegal immigrant who was injured while selling ice cream from a street cart. The seller obtained ice cream from the defendant at a wholesale price and kept profits from sales to the public. He paid for dry ice, but did not pay for the ice cream until it was sold. He was not told how, when and where to sell. He worked 11 hours per day, 7 days per week and, at the end of each day, returned the cart to the defendant along with the unsold ice cream for storage.

The seller testified he had been brought across the Mexican border illegally by a coyote and was to pay the defendant $450.00 for arranging the border crossing. At the time of the accident in which the seller was injured, he had only paid $150.00. After his border crossing, the seller slept at the defendant's ice cream factory along with the 11 others who crossed the border. None of the other venders sold ice cream for anyone else. The seller never paid rent for the ice cream cart. The defendant accepted California or Mexican I.D. to prevent the theft of the ice cream carts, which he rented to the sellers for $2.00 per day. The defendant belonged to an association of wholesalers and when a cart was stolen, the name of the thief would be circulated so that other wholesalers would not sell the vendor any ice cream.

The Workers' Compensation Judge's conclusion that the seller was an independent contractor was upheld by the Appeals Board in its denial of Reconsideration, but was overturned by the Appellate Court. Although the defendant did not interfere with seller's hours, routes, prices and methods of selling, the seller had no real choice as to the terms of the engagement through arms length negotiations, a prime indicator of a true independent contractor relationship. The Court found that the seller was virtually dependent on the defendant, without investment funds or bargaining power. Knowledge of this fact on the part of the defendant was imputed by the fact that the defendant accepted Mexican identification. The defendant not only provided the product, the defendant provided the only means to sell it, along with storage at the end of each day. The seller obviously could not afford to buy his own cart, and the defendant/employer intended to gain more than $2.00 per day by having his ice cream sold along with the cart rental. The Court noted that control is attainable through economic leverage as well as worker incentives. The facts were similar to *Yellow Cab Cooperative Inc. vs. Workers' Compensation Appeals Board*, (1991) 56 CCC 34, in which the drivers were determined to be employees despite a cab leasing independent contractor agreement

because the cab company retained pervasive control over the whole enterprise and direct control over certain aspects of the work. As in *Yellow Cab*, the ice cream seller's money flowed to the defendant, which the court held to be atypical of an independent contractor relationship. The Appellate Court found the seller to be an employee.

2. *Carter v. WCAB (Miller)* (2001)66 CCC 1346 (writ denied).

A residential homeowner hired the applicant. Applicant was injured when he fell off the roof, suffering a skull fracture with resultant head injury and hearing loss. In an F&A the WCJ found the applicant was a residential employee as defined in L.C. §3351(d) and not excluded from coverage under L.C. §3352(h).

Defendant sought reconsideration, contending applicant did not work for defendant for the required 52 hours in the 90 days immediately preceding the 11-8-99 injury, pursuant to L.C. §3352(h).

In his report and recommendation on reconsideration, the WCJ indicated that if the hours applicant worked on the date of injury were excluded, he would not have worked the required 52 hours in the 90 days immediately preceding the date of injury, but if the hours worked on the date of injury were included, the applicant did not work the requisite hours. The WCJ included the hours applicant worked on the date of injury. Based on the case of *20th Century Insurance v. WCAB (Vega)* (1993) 58 CCC 278 (writ denied).

The WCJ concluded applicant was an employee on the date of injury. The WCJ, based on the *20th Century Insurance* case, contends that the clear and legislative intent was to include the hours worked on the date of injury.

The WCAB denied reconsideration and affirmed the WCJ, adopting and incorporating the WCJ's report. The WCAB also stated that the same result was reached in the case of *Basilico v. Truck Insurance Exchange* (1993) 21 CWCR 298, where a Board panel held that a gardener's hours worked on the day of injury may be used to meet the 52-hour requirement, including three hours worked after the injury.

The panel noted that it would defy logic, as well as the spirit and intent of workers' compensation law, to so narrowly construe L.C. §3352(h) that hours worked on the date of injury would be excluded in the calculations. A reading of the relevant Labor Code sections fails to disclose any intent to so narrow the application of law that hours worked on the date of the accident should be excluded. In the *Basilico* case, the defendants argued that including hours worked on the date of injury violated the plain meaning of the statute. In *Basilico* the defendants unsuccessfully sought review before the Court of Appeal and Supreme Court.

The Board then went on to state that they are persuaded that a fair, reasonable, and rational interpretation of L.C. §3352(h) would include the hours worked on the date an employee sustained the injury rather than denying benefits to an employee who actually worked all of the hours required by the code section. The defendant's petition for writ of review was denied.

III Insurance Coverage

IV Injury AOE-COE

1. *Allied Signal, Inc. v. WCAB (Briggs)* (2001) 66 CCC 1333 (writ denied).

Applicant worked for defendant as a network controller. On April 28, 1999, while at work, the applicant went to the rest room, urinated, buttoned up, and turned towards the sink to wash his hands. As he turned away from the urinal, he felt a rushing sensation in his back. By the time he reached the sink, he felt a strong pain. As a result of the back condition, applicant had to take time off work and receive medical treatment. The WCJ found the condition was not AOE/COE. Applicant filed a petition for reconsideration. The applicant contended that the causal connection is established when the injury occurs in the course of employment while an employee is performing normal body movements unless there is a positive showing that the sole cause of the injury is an inherent defect of the employee.

The WCJ recommended that reconsideration be denied. The WCJ stated that the mere fact an employee becomes symptomatic at work while turning in a normal manner is insufficient to prove injury, and under the state of the evidentiary record, applicant did not provide sufficient proof, by a preponderance of the evidence, for a finding of injury AOE.

The WCAB granted reconsideration and found the applicant sustained an injury AOE/COE. The Board reasoned that if disability is precipitated by a movement incidental to the employment, the injury is compensable even though the movement is normal. *Pomona Valley Hospital Medical Center v. WCAB* (2000) 65 CCC 967. If, on the other hand, the injury is wholly spontaneous, it is not compensable just because it occurs on the job. *Reade v. State Compensation Insurance Fund* (1939) 4 CCC 162.

Thus, from an evidentiary standpoint, causal connection will be deemed established when the injury occurs in the course of employment while the employee is performing normal body movements, unless there is a positive showing the sole cause of the injury is an inherent defect of the employee. *Smith v. WCAB* (1971) 34 CCC 424.

After reviewing the record, the Board concluded the applicant met his burden of proving injury AOE/COE. The record reflected the applicant was performing his

job when he needed to use the rest room. In the opinion of the Appeals Board, under the personal comfort or personal convenience doctrine, the course of employment was not broken when he used the rest room.

The WCJ determined the injury resulted from a normal body movement, and as such, it was noncompensable, but defendants had failed to prove that the injury to applicant's back was wholly spontaneous, resulting from an inherent defect of the applicant. Here the disability was precipitated by a movement incidental to employment. Under these circumstances, any reasonable doubt as to the mechanics of the injury were resolved in favor of the injured worker per L.C. §3202.

Defendants filed a petition for writ of review, which was denied.

2. *Anderson v. Safeco Ins. Co.* (2001) 29 CWCR 186 (Board Panel Decision).

The applicant, a hotel houseperson, clocked out after work on June 8, 2000, and left the hotel through an unauthorized exit. Immediately outside the door she slipped and fell on some liquid and injured her back and right hip. The defendant denied liability on the grounds the applicant was no longer in the course of her employment when she used the unauthorized exit.

At a hearing, defendant conceded that, although the door was marked as an unauthorized exit for employees, employees continued to use it, and no employee was ever disciplined for doing so. Following the hearing, the WCJ found the applicant was no longer in the course of her employment when she used the unauthorized exit and ordered that she take nothing. Applicant filed a petition for reconsideration. The Board granted reconsideration and found the injury compensable. The Board indicated that the current law is that if employees perform duties of employment in an unauthorized manner, they do not depart from their course of employment. *Associated Indemnity v. IAC (Macfie*) (1941) 6 CCC 129. An employee's transgression of rules or instructions is within the sphere of employment. Illegal, or even criminal conduct, in the course of employment does not automatically remove the worker from the course of employment. *Williams v. WCAB* (1974) 39 CCC 619.

The question presented is whether the applicant's injury occurred during the applicant's efforts to do her duties of employment in an unauthorized manner or occurred when she was doing an unauthorized activity and was no longer in the course of her employment. There is a distinction between an unauthorized departure from the course of and the performance of an authorized duty in an unauthorized manner. When doing an authorized activity in an unauthorized manner, the injury is still compensable. If, however, the injured has departed from the course of her employment and is no longer performing an authorized duty for the benefit of the employer, the injury is noncompensable.

In this case, the applicant's leaving the hotel through an unauthorized exit did not constitute a departure from the course of employment. The applicant was doing an authorized act in an unauthorized manner when she was injured, and therefore that makes this a compensable injury under applicable case law. The Board granted reconsideration and made a finding that applicant's injury arose out of and occurred in her employment and returned the matter to the trial level to resolve all further issues.

3. *City of San Diego v. WCAB (Molnar*) (2001) 66 CCC 692.

San Diego police officer was required by a subpoena to attend a court proceeding on a day that was not his scheduled day to report for duty. He was scheduled to testify in a matter arising out of his police work as a patrol officer. While the applicant was driving his personal car from home to the courthouse, he was injured in an accident. The applicant filed a workers' compensation claim. The city denied the claim based on the going and coming rule. The WCJ found that, based on the special mission exception to the going and coming rule, the applicant's commute to the courthouse was in the course and scope of his employment. The city sought reconsideration, which was denied by the Appeals Board.

Workers' compensation benefits are precluded for injuries sustained during an employee's normal commute to and from work. This is called the "going and coming rule" and is based on the principle that the employee is not rendering service that benefits the employer during the commute. The special mission exception applies when the employee is requested to perform an unusual service or a usual service at an odd hour during the commute. The trip becomes special because the bother and effort of the trip itself is an important part of what the employee is being compensated for.

To support the existence of a special mission, the underlying activity must be (1) special, that is, extraordinary in relation to the employee's routine duties, (2) within the course of the employee's employment, (3) undertaken at the request or invitation of the employer. The defendant in this case claims the applicant cannot establish the first prong of a special mission because testifying in court is part of his routine duties as a traffic officer. The Court cited the case of *Baroid v. WCAB* (1981) 121 Cal.App 3rd 558, holding that an employee whos regular work day began at 8:00 a.m., but who was frequently required to work additional hours and whose commute to work at 5:00 a.m. was not unusual or extraordinary does not come within the special mission exception of the going and coming rule.

The Court also cited *Luna v. WCAB* (1988) 199 Cal.App.3rd 77, where a police officer was injured while driving his personal car to the police station at an earlier time than normal to report for duty so that he could direct traffic for an annual art festival. The Court of Appeal found that the applicant's shifts were routinely extended to meet additional needs, the festival had been an annual event for more than fifty years, and officers were expected to work extra hours during the festival

and received overtime pay for their efforts. The officer's commute was not an unusual or special trip that brought him under an exception to the going and coming rule.

The Court concluded that the analysis in those cases applies to this case. The record shows that an integral part of the officer's duties was to testify, if subpoenaed to do so, in proceedings arising out of his or her patrol work, and that an officer testifies at such proceedings an average of twice a month. The testimony in the case also established that it was not unusual for officers to be called in to testify on days where they were not scheduled to report to the station, and the police department had various policies applicable to officers who testified on off-duty days. According to one such policy, the officer received overtime compensation for testifying on his off-duty day. The Court stated that the common thread of the cases involving a special mission is that there is some deviation in the location, nature, hour, and the work to be performed that distinguishes the special mission from the normal work commute.

In this case there was nothing extraordinary about the applicant's travel to the courthouse. The nature, location and timing of the work were part of the customary work and responsibilities of the applicant, and his travel to the courthouse was a commute that he regularly made carrying out his duties as a police officer. Although the police department required the officer to attend court to testify regarding matters arising out of his work, his travels to court did not provide a special benefit to the city different than his commute to the police station to report for duty. The Court concluded that the officer's commute was not a special mission exception to the going and coming rule.

4. *Fremont Compensation Insurance Company v. WCAB (Schuman)* (2001) 66 CCC 579 (not published).

The applicant was employed as a security guard at a gated community. The employer provided maintenance, landscaping and security for the community. When working, the applicant parked his car in a dirt field across the street from the community. The employer did not have any on-site parking for the employees. The employer did not own or lease the dirt field where the applicant parked his car. People other than employees used the dirt field to park, including employees of a nearby golf course. The dirt field is directly across the street from the gated community, and about 50 yards to the west is a controlled traffic signal. There was no crosswalk between the dirt field and the entrance to the gated community. The employees did not walk down to the controlled signal, but would jaywalk between the dirt field and the entrance.

One evening the applicant clocked out, and while jaywalking to the dirt field to get his car, he was struck and killed by a passing motorist. The applicant's widow filed a claim, and the WCJ awarded death benefits,

finding that the death was compensable because the applicant was exposed to a special risk, making the going and coming rule inapplicable. The WCJ found that it was only the defendant's employees who parked in the dirt field, contrary to the evidence presented. He found that the employees were forced to park in the dirt field because the defendant failed to provide parking. The WCJ held there was no public risk, only employee risk.

The courts have held non-compensable an injury that occurs during a local commute enroute to a fixed place of business at fixed hours in the absence of special or extraordinary circumstances. One exception to the going and coming rule is the special risk exception such that if a condition on or off the employer's premises creates a special risk of harm to an employee about to enter, or who has just left the premises, the injury is within the course of employment.

The test to determine whether there is a special risk is set forth in *General Insurance Co. v. WCAB (Chairez)* (1976) 41 CCC 162. The exception will apply if: (1) "but for" the employment the employee would not have been at the location where the injury occurred and (2) the risk is distinctive in nature or quantitatively greater than risks common to the public. In *Chairez* the employee was struck and killed by a passing motorist when he exited his car which he parked on the street in front of his place of employment. Chairez's death was non-compensable because the injury did not meet the second prong of the test. His risk was the same as that shared by the general public.

The court found that the case at bar is similar to that of Chairez, and that it does not meet the test that the employee's risk is greater than that of the general public. Here the applicant's reliance on the "left turn" cases is not justified to conclude that the employee was required to make a left turn onto the employer's premises in order to begin or conclude the workday. In effect, the making of a left turn was a condition of employment. But here, the employees were not required to park in the dirt field, nor were they required to jaywalk in order to go to or from work. Therefore, the special risk exception to the going and coming rule does not apply here. The court ruled for the defendant.

5. *Gonzalez v. Republic Indemnity Co.* (2001) 29 CWCR 219 (Board Panel Decision).

Applicant was employed as a production supervisor. The applicant was terminated. The applicant claimed a back injury before he was terminated. The defendant denied liability pursuant to L. C. §3600(a)(10), which provides that no compensation shall be paid if the claim is filed after notice of termination unless it is shown, among other things, the employer had notice of the injury before termination. The applicant claimed the employer had notice of the injury before termination.

The WCJ, after a hearing, found that applicant sustained an injury which caused permanent disability of 20 percent and need for further medical treatment. The judge rejected the L.C. §3600(a)(10) defense because he concluded the employer had constructive notice of the injury before the notice of termination. The defendant filed a petition for reconsideration.

The WCAB panel concluded that the evidence did not justify the WCJ's finding that the employer had notice of the injury, as provided in L. C. §5402, before the notice of termination. The WCAB said that an employer is not liable for injuries occurring before the employee is notified that the employment is being terminated unless a preponderance of the evidence shows that the employer had notice of the injury before informing the employee of the termination. (L.C. §3600(a)(10)).

L.C. §3600(a)(10) refers to the kind of notice provided in L.C. §§5400 through 5413. L.C. §5402 defines such notice as knowledge of an injury obtained from any source by the employer, a managing agent, superintendent, foreman, or other person in authority, or knowledge of a claim of injury sufficient to afford the employer an opportunity to investigate the facts.

The WCAB, citing *Wagner v. Zurich American Ins. Co.* (2001) (WCAB en banc) 66 CCC 483, determined that knowledge of an injury or claim of injury sufficient to obligate an employer to provide a claim form under L.C. §5401(a) calls for a reasonable certainty that the employee suffered or claims to have suffered an industrial injury. Mere supposition or possibility of knowledge is not sufficient to trigger a duty to provide a claim form. An employer is not required to speculate as to employee's unannounced intentions or nebulous, ambiguous comments that only remotely imply a possibility of injury or claim of injury. An employer, aware of facts that would lead a reasonable person to conclude with some certainty that an industrial injury has occurred or is being asserted, has a duty, under the reasonable certainty standard, to investigate. The standard does not require that medical causation be substantiated by a medical report.

The Board concluded that the reasonable certainty test of *Wagner* applies to L.C. §3600(a)10. The Board, when applying the reasonable certainty test to the record before it, said the evidence did not support the WCJ's finding of constructive notice. The applicant claimed to have told four people about his back injury. Of these, only the fellow employee corroborated applicant's testimony, but he was neither a managing agent, superintendent, foreman, nor other person in authority. Notice to employee's co-employee is not notice to the employer. *Reynaga, Jr. v. WCAB* (2001) 62 CCC 380 (writ denied).

The other witnesses all denied knowledge of either the injury or the claim. The employer knew the applicant claimed a pelvic injury while cleaning a drum and offered to provide medical treatment and a claim form, but the applicant declined the offer. However, notice of that claim, moreover, could not, constructively or otherwise, be notice of an injury to another part of the body on a different date.

The applicant was claiming a back injury while installing a fence on the employer's premises. When the applicant was told he was being investigated, he became angry and told his supervisor that while cleaning a drum, he injured his pelvis. The Board went on to say notice of the pelvic injury could not constructively, nor otherwise, be notice of an injury to another part of the body on a different date.

The Board went on to state that the applicant's testimony about his conversations with his supervisors was vague and he modified his account after having his memory refreshed by his deposition. Both supervisors contradicted his testimony.

In the opinion of the Appeals Board, the applicant did not meet his burden of demonstrating by a preponderance of evidence that he gave notice of a back injury before he was terminated. The Board indicated that after reviewing the record, it was exercising its power to reweigh the evidence as provided in *Allied Comp. Insurance Co. v. IAC* (1961) 26 CCC 241. The panel granted reconsideration, rescinded the WCJ's Findings and Award, and substituted a finding that applicant's claim was barred by L.C. §3600(a)(10) and an order that applicant take nothing, other than medical-legal costs.

6 *Jones v. Lassen County* (2001) 29 CWCR 14 (Board Panel Decision).

Applicant was employed by Lassen County as a Family Support Officer. Her office was in a mall. Management of the mall requested that all employees of the mall tenants park in a lot which was located on the other side of an alley that ran past the back door of applicant's place of employment. The defendant County did not require the applicant to park in that lot. The applicant was injured when she tripped on ice in the alley and fell approximately 10 to 15 feet from the back door of the County facility. At trial the WCJ found the injury occurred before applicant reached her place of employment and was, therefore, noncompensable because it came within the going and coming rule.

In a two to one decision, the Board, after reviewing several parking lot cases, said that the cases established that when the employment reasonably contemplates that an employee will use an employer provided parking lot, the employment relationship commences when the employee enters the employer's parking lot even though it is necessary to cross a public street to get to the work site. The Board cited *Lewis v. WCAB* (1975) 40 C.C.C. 727. The Board went on to state that even if the employer does not own the lot, an employee using it with the employer's knowledge is in the course of employment when taking the most direct route from the lot to the work site. The Board cited *Point Sal Growers v. WCAB (Ramirez)* (1986, writ denied) 51 CCC 53. The Board went on to state this is particularly true if the employer intends that employees park in a lot that it doesn't own. Citing *Ultramar Diamond Shamrock v. WCAB (Dzuro)* (2000) 65 CCC 983.

Applying these principles to the facts of this case the Board indicated the applicant was injured while crossing an alley between the parking lot nearest her

employment and a building in a mall. The lot had been designated by the mall as preferred for employee parking, even if parking in the lot was not specifically required by the employer. Under these facts, the injury is compensable and is not excluded from compensation by the going and coming rule. Reconsideration was granted and a decision issued finding injury and returned the case to the trial level for all other issues.

(Editor's Note) This case seems consistent with a line of cases that say anytime you are injured in a common area of a building or space that the employer is allowed to use as a common area as part a lease, the injury is compensable. When a company leases a building that has parking as part of the lease for free, this would appear to be part of the common area and, therefore, an injury there would be compensable. This case is consistent with that theory.

7. *Lee v. City of Visalia* (2001) 29 CWCR 257.

Applicant suffered a cumulative trauma injury to her spine and psychiatric arising out of her employment during a period ending September 24, 1997 and a cumulative upper extremity injury that first caused disability on December 30, 1997. Applicant also filed an application claiming a cumulative psychiatric injury ending February 1996.

Applicant was initially evaluated in 1996 by a Dr. Sharma, who mentioned that she had symptoms for two years. Dr. MacMorran, a QME in orthopedic surgery, found applicant permanent and stationary on October 20, 1998. The psychiatric disability was declared permanent and stationary on December 28, 1998.

Defendant's self-insured employer filed a declaration of readiness to proceed, declaring discovery was complete and they were ready to proceed to hearing. At the trial the defendant moved for additional evidence. The WCJ denied the motion, and the matter was submitted for decision. The WCJ found that the admitted injuries caused permanent disability of 67 percent after apportionment to the 1996 cumulative injury, which the judge found barred by the statute of limitations.

Both parties and lien claimant petitioned for reconsideration. Defendant petitioned for reconsideration, arguing that there should have been further development of the record on the issue of apportionment, and applicant contended the apportionment was not justified.

On the issue of the defendant's petition for reconsideration regarding the presentation of further evidence, the Board indicated that defendant filed a Declaration of Readiness to Proceed to Trial and indicated that their discovery was complete and they were ready for trial. The burden of proof on apportionment is on the defendant. Defendant did not object to the WCJ's submission order.

In the opinion of the Board, the defendant has not made a case for augmenting the record. The Board indicated this was not a case where neither side had presented substantial evidence on which a decision could be based.

The Board then turned to the applicant's petition for reconsideration. The Board cited the case of *Hooker v. WCAB* (1974) 39 CCC 75, which concluded that so long as the repetitive trauma continues to cause further disability, recovery may be had for such disability as has occurred within one year of the filing of the application.

Based on the Hooker case, the panel stated where there is a prior cumulative trauma which is barred by the statute of limitations, any temporary disability or self-procured medical treatment related to the prior cumulative trauma may be barred, but there is no apportionment of permanent disability unless it is established that the prior cumulative trauma became permanent and stationary before the subsequent cumulative trauma that has not been barred by the statute of limitations.

In this case the medical reports established that applicant's disability from all the injuries did not become permanent and stationary until well after the filing of the application for the 1996 injury. Therefore, there was no basis for apportionment, and applicant is entitled to an 87 percent permanent disability rating before apportionment to the 1996 cumulative injury.

The Board then remanded the matter back to the WCJ on the issue of the change in attorney fee for the added permanent disability and life pension. The Board denied lien claimant's and defendant's petition for reconsideration and issued a decision that the injury caused permanent disability of 87 percent.

8. *McCalip v. Legion Insurance Company* (2001) 29 CWCR 280 (Board Panel Decision).

Applicant was employed as a tile setter. Applicant and other employees customarily reported to the company shop each morning for their work assignments. Company trucks were used to take employees and tools to job sites, but some employees drove their own cars to the job sites. Although the employer condoned employees taking their own cars to the job site, it did not reimburse employees for use of their personal vehicles.

The employer supplied tools, but the applicant and some others also supplied their own tools. At the end of the day, the employees loaded the company truck for return to the shop where the sand buckets were refilled for the next day. Employees who drove their own cars were not required to return to the shop when they had finished their work assignments.

On November 4, 1998, the applicant and a supervisor were assigned to a remote job site. They finished the job shortly after noon and had no further work to do at that location. The supervisor took the truck, including applicant's tools, back to the shop. Applicant left in own car but did not tell the supervisor where he was going. At the time of the injury, the applicant was headed in the direction of both his home and the shop when he ran off the road and was injured.

Defendant denied liability based on the going-and-coming rule and intoxication defenses. At the hearing on the matter, the applicant testified that he customarily drove his own car because he wanted the freedom to get his own lunch and because he sometimes had side jobs to go to at the end of the day. It was for the side jobs that he used his own tools and carried them in his own car.

Due to his head injury, he had no memory of the events of the day of the injury and had no knowledge why his tools were in the company truck. He inferred from his usual practice of carrying them in his car that he expected to do additional work for the employer that day. It was unusual for his tools to be in the company truck.

The workers' compensation judge concluded the applicant was "on the clock" at the time of the injury and found that the injury was not caused by intoxication. Defendant petitioned for reconsideration, contending the claim was barred by the going-and-coming rule and by the intoxication defense. In his report and recommendation, the WCJ stated that based on the facts and L.C.§3202, the only reasonable conclusion was the applicant was returning to the shop either to fill the sand buckets and check on last-minute work or to get his tools. The WCAB granted reconsideration for further study.

The Appeals Board panel, after further study, found the judge reached the correct result and denied reconsideration. The WCAB concluded that it was reasonable for the WCJ to infer that applicant was returning to the shop. Based on the scene of the accident, the applicant could have been headed home or back to the shop. Because of the applicant's amnesia, he could not remember where he was going nor what he was doing. Nevertheless, it was reasonable for the judge to infer that the applicant, being the helper, would likely have been responsible for refilling the sand buckets.

The fact the applicant's tools were in the truck supported the judge's conclusion that the applicant was probably returning to the shop. The Board concluded that the judge could reasonably infer that the applicant was returning to the shop either to get his tools, help load the sand, or was checking to see if there were other jobs for the rest of the day.

The panel did not, however, approve of the WCJ's conclusion that applicant was "on the clock" at the time of the injury. The applicant had finished his duties at the site, and there was no evidence either way on whether the employees were being paid for the time spent traveling between the shop and the work sites. The panel

also summarily disposed of the intoxication issue by incorporating the WCJ's reasoning that the defendant did not produce sufficient evidence to establish that applicant's injuries were caused by any alleged intoxication. The findings of the WCJ were affirmed.

V. Conditions of Compensation

1 *Atlantic Mutual Insurance Co. v. WCAB* (2001) (writ denied) 66 CCC 370.

Applicant worked as an outside sales executive. In a Findings and Award, the WCJ found applicant sustained injury AOE/COE to her psyche and internal system. Defendant sought reconsideration claiming that applicant's inability to cope with changing market conditions was not an actual event of employment as required under L.C. §3208.3(b)(1), and the change in defendant's commission structure was a good faith personnel action under L. C. §3208.3(h).

The WCAB granted reconsideration, and reversing the WCJ, found no injury AOE/COE to applicant's internal system. However, the WCAB affirmed the WCJ's finding of injury AOE/COE to applicant's psyche. The WCAB stated that Dr. Bloch found that the applicant developed physical and emotional symptoms when the pay structure changed, quotas were increased, and applicant's supervisor tried to get her to accept a lower paying position. Though the doctor noted she had several nonindustrial stressors in 1996, the doctor felt the applicant had coped well and would have been asymptomatic without the change in her work environment in April 1997. Dr. Bloch concluded that actual events of applicant's employment were predominant to all causes combined of her psychiatric injury and that she was temporarily totally disabled.

The WCAB, discussing the actual events of employment requirement of L. C. §3208.3(b)(1), stated that the evidence established that there was a change in the market in April of 1997 which resulted in a reduction in sales causing applicant to have difficulty meeting her quota for sales. Also, there was a change in defendant's commission structure, and applicant was offered a lower-paying job at a fixed salary. These are actual events of employment, which fact is undisputed.

The testimony of the applicant and her supervisor established that the employer increased the sales quotas of the salespeople and changed their commission structure, which resulted in decreased earnings and lower morale. Also, the employer was aware that there was increased competition at the time. Applicant testified that competitors offered lower prices and lower costs for services, but applicant was unable to reduce the employer's prices. The applicant lost accounts and was unable to attract new ones. The applicant's supervisor noted she was not meeting her quotas and that he had reassigned some of her accounts to other people.

In the Board's view, the employer's actions did not constitute a good faith personnel action under L. C. §3208.3(h), and the Board was persuaded the applicant sustained a compensable psychiatric injury as a result of employment. They affirmed the judge's findings with respect to the industrial injury to the psyche. Defendant's writ of review was denied.

2 *Pearl v. WCAB* (2001) 66 CCC 823.

The applicant worked as a police officer for Cal Poly from 1990 to July 1996, when he applied for a PERS retirement, alleging injury to his psyche. In 1997, PERS approved his applicant, but granted him a nonservice-connected retirement. The applicant petitioned for a special finding with fact under Government Code §21166 finding that his disability was industrial which would entitle him to a service connected retirement which pays greater benefits. The applicant's doctor found a cumulative trauma accounting for 51% industrial causation. The defense doctor found that actual events of employment caused only 25% of the applicant's disability. The WCJ made a finding on the opinion of the defense doctor and denied the applicant's petition under Labor Code §3208.3 as amended in 1993. That section requires that causation be the predominant cause to find a compensable psychiatric injury. The applicant sought reconsideration which the Appeals Board denied on the basis that Labor Code §3208.3 is incorporated into Government Code §21166. The Court of Appeal denied review, but the California Supreme Court granted review and transferred the case back to the Court of Appeals.

On rehearing, the Court of Appeal again held the L.C. §3208.3 is applicable and raises the threshold for causation as to a psychiatric injury and found that the increased threshold applies to public employees as well. The court found that the higher threshold did not interfere with the applicant's vested rights since his right to increased benefits was contingent upon his later psychiatric injury. Again the applicant sought review by the Supreme Court.

The Supreme Court affirmed that the WCAB has jurisdiction on the limited issue of industrial causation with the respect to a PERS retirement. As to PERS retirements, the Court applied the more liberal standard of Government Code §20046 which requires the industrial component to be "real and measurable". The Court stated that L.C. §3208.3 was not intended to apply to PERS retirements because, if it did, it would have said so. The Court noted that the standard set forth in L.C. §3208.3 only applies to injuries under Division 4 of the Labor Code. Retirement comes under a different legislative scheme, and, therefore, Government Code §20046 is the applicable standard to apply here. Absent clear legislative direction, it cannot be assumed that the provisions of the Labor Code would apply to a PERS retirement benefit. There is no clear indication that the legislature was attempting the change the standard for a PERS retirement in adopting the 1993 amendments to L.C. §3208.3. The purpose of that amendment was to eliminate the filing of fraudulent psychiatric claims before the WCAB. The legislature was

not concerned about fraud or abuse in PERS claims. The Supreme Court unanimously reversed the decision of the Court of Appeals in finding that the standard to apply in a PERS where the issue is causation of psychiatric injury is set forth by Government code §20046 and not the more restrictive standard set forth in L. C. §3208.3.

3 *Rolda v. Pitney Bowes*, Inc. (2001) 66 CCC 241(Board En Banc).

The WCJ found that applicant, while employed as a salesman sustained injury arising out of and occurring in the course of employment to his psyche. In his Opinion on Decision the WCJ stated that applicant's psychiatric injury was not the result of a good faith personal action. Defendant's petition for reconsideration contended that any psychiatric injury sustained by applicant was caused by a good faith personal action within the meaning of L.C. §3208.3(h) and therefore, no compensation is payable.

Applicant was employed by defendant as a business machine salesman. He was assigned territory in which to work. The applicant's supervisor was Mr. Brown. Applicant was apparently dissatisfied with the manner with which Mr. Brown handled at least two episodes involving disputes between applicant and other salesman over territory and clients. Mr. Brown did not deem the applicant's performance as a salesman to be fully satisfactory, and according to applicant, recommended sometime in the first quarter of mid-1997, that he should consider resigning. Another supervisor apparently told the applicant on at least one occasion this job may not be for him. Applicant told Mr. Brown in the second or third quarter of 1997 he was suffering from stress during a conversation about customers.

Prior to applicant taking a vacation-leave of absence commencing October, 1997 in the Philippines, where a relative was dying of cancer, applicant filed claims for orthopedic and psychiatric cumulative injuries sustained while working for Pitney Bowes. The primary basis for applicant's psychiatric claim was that he was discriminated against and harassed by Mr. Brown and other supervisors. A letter was sent by defendant to applicant's residence informing him that they were approving his request for extended leave of absence, but the letter noted, however, there was no guarantee of re-employment, that his territory may be filled and that he should contact Mr. Brown at least two weeks before his anticipated return to see if his territory was available.

Upon applicants return from the Philippines his territory had been reassigned. He declined defendant's offer of other territories that were a substantially greater distance from his home and never returned to work for the defendant. Dr. Brian Jacks, reporting for defendants, concluded that the applicant's difficulties seemed to be due to routine personnel actions or lawful non-discriminatory personnel actions. Further, the doctor found the applicant was most concerned and upset about being fired, being out of work, having financial problems and difficulties

locating a new job. Finally the doctor indicated there were non-industrial stresses of two deaths in the family. The doctor found the predominant cause of applicant's emotional disability to be non-industrial. Dr. Thomas Curtis, reporting for the applicant, concluded that he sustained an industrial psychiatric injury. Dr. Curtis found a convincing description of humiliation, mistreatment and discrimination against him as a foreign born Filipino man. The doctor also found emotional complications of physical trauma, pain and disability, due to work. The doctor concluded that applicant's emotional symptoms arose out of his work at Pitney Bowes.

The matter proceeded to trial and the applicant was the only witness. Following the hearing, the judge allowed supplemental reports from both psychiatrists. At a subsequent hearing, Mr. Brown, who was applicants direct supervisor and Mr. Richman, another supervisor, testified. There was conflicting testimony as to whether Mr. Brown had ever suggested the applicant resign. Mr. Brown did agree that the applicant's position was stressful and testified the applicant had difficulty meeting his sales goal. The WCJ, following submission, issued a findings and award in which he determined that applicant had sustained an industrial injury to his psyche while employed as a salesman. In his opinion on decision the WCJ indicated he relied on Dr. Curtis' opinion and applicant's testimony. Without further analysis the WCJ stated that applicant's psychiatric injury was not the result of a good faith personal action.

In an en banc opinion on decision the Appeals Board concluded that a multi-level analysis is required when a psychiatric injury is alleged and the defense of lawful discriminatory good faith personal action has been raised. First, the WCJ must determine whether the alleged psychiatric injury involved actual events of employment, and if so, whether competent medical evidence establishes the required percentage of industrial causation. If these two conditions are met, the WCJ must then decide whether any of the actual events were personnel actions. If so, the WCJ must next determine whether the personnel action or actions were lawful, non-discriminatory and made in good faith. Finally if all these criteria are met, competent medical evidence is necessary as to causation; that is, whether or not the personnel action or actions are a substantial cause, accounting for at least 35 to 40 percent of the causation from all sources combined.

The Board stated the first determination that must be made is whether actual events of employment are involved. This is a factual legal issue for the WCJ to determine, not a medical issue. The next determination, causation of the psychiatric injury, however requires competent medical evidence. Under L.C. §3208.3(h), the causation threshold is predominent as to all causes combined, or a substantial cause where the injury resulted from being the victim of a violent act. While substantial cause is defined as at least 35 to 40 percent of the causation from all sources combined, the phrase predominent to all causes is not defined in the statute itself, nor elsewhere in the Labor Code. However, in *Department of Corrections/State of California v. W.C.A.B.* (Garcia) (1999) 64 CCC 1356, the

court stated that this phrase was intended to require the work related cause as greater than a fifty percent share of the entire causal factors. The Board next stated that, assuming both threshold of compensable psychiatric injury has been met under §3208.3(h), and the employer has asserted that the injury is nonetheless barred as having resulted from a personnel action as defined by subdivision (h), the WCJ must then decide whether any of the actual events of employment were personnel actions, and if so, whether any of them were lawful non-discriminatory good faith personnel actions. These are factual/legal issues for the WCJ to determine. Finally if any, non-discriminatory, good faith personnel actions contributed to the injury, medical evidence is required to determine whether such personnel actions were substantial cause, (35 to 40 percent) as set forth in subdivision (a)(3).

The Board stated the foregoing analysis requires the evaluating physician take a history of all events alleged to have contributed to psychiatric injury, and to render an opinion as to causation in terms of, first, whether the employment events were a predominant cause (greater than fifty percent cause of the injury). Then, where it has been claimed, the applicant's injury was the result of a lawful, non-discriminatory good faith personnel action, the evaluating physician must also offer an opinion as to the percentage of causation for such alleged or apparent actions.

The Board then ruled that neither the WCJ's decision, nor his report on reconsideration, nor the medical evidence, including that relied on by the WCJ, complies with the multi-level analysis necessary to determine the compensability of the psychiatric injury alleged. Accordingly, they rescinded the findings and award and returned the matter to the trial level to further develop the record.

VI Presumptions (except presumption of correctness of primary treating physician).

1 *Hurt v. Kaiser Foundation Hospital* (2001) 29 CWCR 221 (Board Panel Decision).

Janene L. Hurt was employed as a registered nurse by Kaiser Foundation Hospital. She suffered from a nonindustrial heart condition known as Marfan's syndrome that had previously caused her temporary disability and a need for medical treatment. She worked for Kaiser under work restrictions because of the condition. On September 14, 1995, she became ill, lost consciousness, and died in the emergency room. The evidence showed no indication that she had done anything strenuous or exceeded her work restrictions that morning.

On December 29, 1995, the defendant received a letter from applicant Randal Hurt, the surviving spouse, stating that "since she died at work, I'd like to know the status of the workers' compensation investigation." On March 14, applicant posted two claim forms by certified mail. It was not clear from the record whether Kaiser received these on March 15 or March 27. On June 10, 1996, defendant's

claims adjuster executed the request for denial. The denial letter was actually written on June 19 and received by the applicant a week later.

On November 28, 1998, the WCJ made a finding that the death was not the result of either a specific or cumulative injury arising out of deceased's employment. He found the death was presumed compensable, but that the presumption had been rebutted by the defense QME report. In his opinion on decision, the judge gave three reasons why the death was presumed to have arisen out of employment: one, an unexplained death on the employer's premises is presumed to have been caused by the employment; two, Kaiser breached its obligation to give applicant a claim form when it received the husband's letter; three, the denial on June 19 was more than 90 days after the March 15 receipt of the claim form.

The judge ruled that although Kaiser could have obtained a rebuttal report within the 90-day period, there was no reason to obtain one until after the applicant obtained a medical report to prove their case. The applicant filed a petition for reconsideration, claiming the defense medical was inadmissible because it could have been obtained with reasonable diligence within the 90-day period from when the claim form was filed.

The Workers' Compensation Appeals Board granted reconsideration for study and, after reviewing the matter, issued a decision remanding the matter back for further proceedings. The Workers' Compensation Appeals Board first questioned the judge's conclusion that an unexplained death on the employer's premises was presumed compensable. Although not cited, *Clemmens v. WCAB* (1968) 33 CCC 186, among other cases, was apparently relied on by the WCJ in applying the presumption.

The Board went on to state that assuming those cases are still good law despite the subsequent adoption of Labor Code §3202.5 (nothing in the liberal construction provision relieves a party from meeting its evidentiary burden of proof), Janene Hurt did not die under mysterious circumstances. She had a serious, nonindustrial heart condition that had previously caused disability, and there was no indication that she had done anything at work to precipitate another episode of her Marfan's syndrome.

The Board then went on to deal with the letter of December 1995 sent to Kaiser by the husband. The issue there is whether the letter gave Kaiser sufficient notice that the applicant was claiming an industrial injury. The panel said the matter should be referred back to the workers' compensation judge to be reanalyzed in light of the board's reasonable certainty test announced in its en banc decision in *Wagner v. Zurich American Insurance Co*. (2001) 66 CCC 483. If on remand the WCJ decides that Kaiser was reasonably certain from the letter that a claim for death benefits was being made, he should take into consideration the rule that the 90-day period begins when the claim form is provided. Its running is tolled from the date

of a belated claim form delivery until the completed claim form is returned to the employer.

The Board, turning to the WCJ's finding that the injury was presumed compensable under L.C. §5402, noted that the WCJ apparently relied on a statement of a Kaiser official that the denial letter was not sent out when the claims adjuster completed the request for denial because medical support was lacking. In concluding that the claim was not denied when the claims adjuster decided to deny it, the WCJ cited *Rodriguez v. WCAB* (1994) 59 CCC 857. Although the evidence of a denial in *Rodriguez* was a letter of denial written on the 89th day, but not received by the applicant until the 96th day, the Court made it clear that L.C. §5402 requires only the rejection be made within 90 days and there's no formal requirement for rejection. Nothing in *Rodriguez* requires medical confirmation when the rejection is made.

The WCAB remanded the matter to the WCJ and instructed the judge that on remand he must determine whether the adjuster's request for denial was adequate evidence of Kaiser's intent to reject the claim. The judge may also clarify whether the L.C. §5402 90-day period began to run on March 15 or March 27, 1996, as his opinion on decision was not clear on this point.

Finally, reaching the issue the applicant raised in the appeal, the panel noted that in concluding that the medical report and the deposition were admissible because the report was obtained promptly after the defendant received the first medical evidence tending to prove the injury compensable, the WCJ relied on several writ-denied cases. Although these cases may support admitting the report, the case of *State Compensation Insurance Fund v. WCAB (Welcher)* (1995) 60 CCC 717, is the controlling authority.

The rule of *Welcher* is that evidence is barred that could have been obtained with the exercise of reasonable diligence during the 90-day period. What constitutes reasonable diligence is to be determined on a case-by-case basis. After reevaluating the evidence in light of *Wagner*, if the WCJ concludes that the L.C. §5402 presumption applies, he must revisit the question of the admissibility of the defense QME report and deposition in light of *Welcher*. Accordingly, the panel rescinded the order and remanded the matter back to the WCJ.

2 *Melville v. WCAB* (2001) 66 CCC 943 (writ denied).

In a findings and award, a workers' compensation judge found injury AOE/COE to applicant for a continuous trauma injury to headaches or neuropsychiatric problems. The WCJ awarded 11 1/2 percent permanent disability and found the applicant may be in need of further medical treatment. Applicant sought reconsideration, contending that defendants had notice of the injury and did not timely deny it under Labor Code §5402, and, therefore, injury AOE/COE should have been found to multiple parts of the body.

The WCJ ruled that the earliest the defendant knew with reasonable certainty that applicant was claiming or suffered an industrial injury was when the defendants received a claim form. Defendant denied the case within 90 days of receiving the claim form, and the WCJ then ruled the presumption did not apply. The WCJ found that a safety report and a union grievance did not provide defendants with the requisite knowledge that applicant was claiming or suffered an industrial injury.

The applicant, on October 16, 1995, filed an employee safety report stating that an 1800-gallon open-air tank containing nitric acid had been releasing chemical vapors into the air. The applicant complained the vapors collected onto the rafters and ceiling and dripped into his work area. The applicant also complained that large pieces of paint were falling from the rafters and that the moisture caused his tools to rust. The applicant stated that he had been feeling ill at work for some time. The record indicates the applicant did not lose any time from work and did not require any medical treatment until February 16, 1996.

The applicant subsequently filed a union grievance on December 15, 1995, stating that he needed "any and all" medical problems to be taken care of by the employer, but he did not state what type of medical problems he had or which parts of the body were injured.

The WCAB, in coming to its conclusion that the employee safety report and the union grievance did not give the employer sufficient knowledge with reasonable certainty that the applicant was claiming or had suffered an industrial injury, cited *Wagner v. Allied Signal Aerospace* (2001) 66 CCC 483 (en banc) for the proposition that the 90-day period begins to run from the receipt of the claim form.

The 90-day period may also run where the employer breaches his duty to provide a claim form when requested by the applicant, citing *Janke v. State of California* (1991) 19 CWCR 310, and must give a claim form when it has knowledge of an injury or that the applicant is claiming an injury that would make an employer reasonably certain under the facts that the injury occurred or the applicant was claiming the injury. Mere supposition or possibility of knowledge is not sufficient to trigger the duty.

The Board, in citing *Wagner*, indicated that in the determination of whether the reasonable certainty standard has been met, an employer will not be required to guess or speculate as to an employee's unannounced intentions or nebulous, ambiguous comments that only remotely imply a possibility of injury or claim thereof. Nor does this standard require substantiation of industrial causation through a medical-legal report. The reasonable certainty standards are meant to impose on the employer a duty to investigate where he or she has been made aware of facts that would lead a reasonable person to conclude with some certainty that an industrial injury has occurred or is being asserted.

Applying *Wagner* to the facts of this case, the Board and the judge indicated that neither applicant's employee safety report nor the union grievance were sufficient to provide notice to the employer of an industrial injury with reasonable certainty. While the employee safety report complained of the working conditions, there was no notice given of the applicant's need for medical treatment other than he stated he was feeling ill. It did not state the applicant was injured, what parts of the body were claimed to have been injured or exposed to what chemicals, whether time from work had been lost, or whether the applicant sought medical attention for any of his claimed injuries.

While the applicant stated in the union grievance that any and all medical problems needed to be addressed by the defendant, he did not specifically identify any problems. Further, the applicant did not take any time off from work and did not seek medical treatment until February 1996.

Accordingly, the board found that the 90-day time limit in which the defendant had to deny applicant's claim did not commence with the October 13, 1995 safety notice or the December 13, 1995 union grievance. Rather, the time limit began no earlier than January 12, 1996, upon applicant's filing of his claim form with the employer. The defendant filed the denial on April 5, 1996, and therefore it was timely.

The petition for writ of review and the petition for reconsideration were both denied.

3 Murphy v. Travelers Property and Cas. Corporation (2001) 29 CWCR 78.

An application was filed claiming an injury consisting of cancer from exposure to chemicals and petroleum. The application was filed on October 5, 1999. The matter concerned a death case filed by the surviving spouse of the allegedly injured worker who died of pelvis cancer. Defendant denied liability on January 3, 2000. An application was filed claiming the cancer resulted from exposure to chemicals at work. At a mandatory settlement conference, the issue of L.C. §5402 presumption was raised. The matter was set for regular hearing. At the hearing the issues were framed and some documents were received in evidence, but no testimony was taken.

The WCJ ruled that the injury was presumed compensable pursuant to L.C. §5402 and excluded defendant's medical evidence because it had not been obtained within 90 days after defendant had notice of injury. He reasoned that, although the denial was within 90 days after the filing of the claim form required by L.C. §5402, the defendant should have given the deceased employee a claim form when it received her leave of absence request, and the time for denial, therefore, ran from that date and not the date on which the claim form was filed. The hearing was then continued.

Defendant filed a petition for reconsideration or removal contending that it would be denied due process if it were not allowed to present evidence to rebut the presumption; that knowledge of an injury cannot be implied where causation is neither obvious nor a matter of general knowledge; that the facts in this case provide no basis to apply L.C. §5402 presumption; that even if a claim had been filed while deceased was still alive, a separate claim form would have been required for death benefits; and that it was error to exclude defendant's medical evidence that was obtained within 90 days after filing of the claim form.

In his Report on Petition for Reconsideration or removal, the WCJ reassessed his conclusion that because the employer knew that it stored carcinogenic material at the sites where the deceased worked, it had a duty to give deceased a claim form when it learned that she had cancer. No evidence was taken on the extent of her exposure other than a rather sketchy history in the report of applicant's medical expert. Further evidence should have been taken on the extent of the exposure before a ruling was made on the employer's duty to provide a claim form. The WCJ, nevertheless, recommended that removal be denied because no irreparable harm had been demonstrated. A Panel concluded that the defendant would sustain substantial prejudice or irreparable harm if it did not remove the case to itself and correct the WCJ's error.

After summarizing the record, the Panel stated that they observed there was no opportunity at trial for the defendant to cross-examine the witnesses as no testimony was presented. They noted that the WCJ's decision was based on the Material Safety Data Sheets submitted by the applicant. The Board examined those Material Safety Data Sheets and noted that this evidence does not indicate whether exposure to those particular chemicals would result in the type of cancer suffered by the applicant. The February 15, 1990 request for leave of absence did not contain any facts that would have reasonably alerted the employer that the deceased's cancer was work related. The deceased was a customer service representative. The fact that the employer produced various toxic substances which are carcinogenics does not necessary imply that the deceased was exposed to them in such a manner that would have caused her to develop pelvic sarcoma, much less, that the employer knew about the exposure or that the substances were implicated in her cancer. Moreover, the UCD claim denied a relationship to work.

After analysis of the record, the Panel remained unpersuaded that there was sufficient evidence in the record to determine whether the employer had notice or knowledge within the meaning of L.C. §5402 that the deceased employee had been injured. It was, therefore, premature to rule on applicability of the presumption or on the admissibility of defendant's medical opinions. Removal was appropriate to correct this error, and it was unnecessary to consider the appropriateness of reconsideration. Accordingly the Panel removed the case to itself and rescinded the orders under attack and returned the case to the WCJ for further proceedings.

4 *Wagner v. Allied Signal Aerospace* (2001) 66 CCC 483, 29 CWCR 103 (Board En Banc).

Applicant was employed from 1982 to 1999. He reported to the employer that he was taking medication to cope with work stress on July 20, 1998. No DWC Form 1 was then provided to the employee. In October 1998 he entered a psychiatric hospital, and his personnel file indicated he was hospitalized for a nervous breakdown. No DWC Form 1 was then provided to the employee. Applicant was placed on disability leave. On January 15, 1999, a DWC Form 1 was received from the employee, and on March 31, 1999, the employer issued a denial of claim.

Documentary evidence was submitted. The WCJ found that the employer had breached its obligation to timely furnish the employee with a DWC Form 1 Claim Form, and that the denial was not filed within ninety days of the breach. The WCJ found, therefore, that the injury was presumptively compensable under L.C. §5402. Defendant sought reconsideration contending that the ninety-day time frame within which to investigate and accept or deny the claim did not commence until a DWC Form 1 was received from the applicant.

The Appeals Board granted reconsideration and rescinded the determination, holding that there was no sufficient determination that the employer's obligation to furnish the claim form arose prior to the date the employee submitted the form. The Board noted that where the employer has knowledge of an employee injury or alleged injury from any source, it is required to provide a DWC Form 1 within one day. Where, as in *Janke v. State of California, Department of Justice*, (1991) (WCAB Panel) 19 CWCR 310, the employer refuses to timely provide the DWC Form 1, the time within which to deny the claim runs from the date of the breach of duty. However, the employer's obligation to provide the form does not arise until the employer is "reasonably certain that the employee had suffered an industrial injury or was claiming one." (*Thompson v. County of Stanislaus*, (1996) (WCAB Panel) 25 CWCR.24.

The Board concluded that in order to have knowledge of an injury or claim sufficient to require an employer to provide a claim form, the employer must be reasonably certain, under the particular facts of the case, that the employee suffered, or claimed to have suffered, an industrial injury. Mere supposition or possibility of knowledge is not sufficient to trigger a duty to provide a claim form. An employer is not required to guess or speculate about an employee's unannounced intentions or nebulous, ambiguous comments that only remotely imply a possibility or injury or claim of injury. The test to be applied is the "reasonable certainty standard." That standard imposes a duty on the employer to investigate. The standard does not require that medical causation be substantiated by a medical report.

In determining whether the "reasonable certainty standard" has been met, the WCJ may develop the record to identify the persons who made the personnel file entries

and determine whether they fall within the class of "persons in authority" as specified in L.C. §5402.

The Board rescinded the findings of fact and returned the case to the WCJ for further proceedings and a new decision.

VII Res Judicata and Collateral Estoppel

VIII Earnings; Indemnity Rate Determination

Fireman's Fund Insurance Company v. WCAB (Moore) (2001) 66 CCC 219 (not published).

Applicant was unemployed from November 1, 1995 through January 1, 1997. During the period from January 1, 1997 through January 22, 1997 he worked as a handyman for 47 1/2 hours a week at $10.00 per hour. Early on, the employer told him that if she was satisfied with his work she would hire him for some additional work beyond January 22. On January 23 she hired the applicant to work for an additional 8 to 12 months and offered him a room while he completed the work. The work was not to start for several weeks so he collected unemployment insurance benefits until he started work on February 19, 1997. On that date he fell off the employer's roof sustaining injuries to his lower extremities. On September 28, 1998 the applicant filed an application claiming weekly earnings based upon 47 1/2 hours a week at $10.00 per hour.

The defendant accepted the claim under the employer's homeowner's policy and paid temporary disability benefits at the rate of $230.00 per week. The parties disagreed on the applicant's average weekly earnings for purposes of determining the permanent disability indemnity rate. The defendant paid the permanent disability at less than the maximum rate. The applicant raised the issue of P. D. and penalty, among other issues, and the matter proceeded to trial.

The WCJ awarded the applicant P. D. at the maximum rate of $230.00 per week in accordance with L. C. §4453(c)(1). The defendant sought reconsideration which the Board granted, but thereafter affirmed the WCJ's opinion as to P. D. rate and remanded the matter to the WCJ on the issue of penalty. The Board noted that, from the record, it was unclear if the WCJ had considered the applicant's past earnings history in determining the P. D. rate and penalty issues.

The defendant argued that the WCJ should have applied L. C. §4453(c)(4) rather than subsection (c)(1) because of the applicant's history of unemployment.

On review the DCA says that both the WCJ and the Board failed to consider the applicant's prior earnings history when rendering these decisions. Under L. C. §5908.5 it is a requirement that any decision or order shall state the evidence relied upon and specify in detail the reasons for the decision.

Here the DCA says the applicable rule is to be found in *Argonaut Ins. Co. v. I.A.C. (Montana*)(1962) 27 CCC 130. The Court says it would not be consistent with the purpose of the statute to base a finding of maximum earning capacity solely on a high wage, ignoring irregular employment and low income over a long period of time. The Board should explain its failure to take the applicant's sporadic work history into consideration.

IX Temporary Disability

State of California, Department of Rehabilitation v. WCAB (Lauher) (2001) 66 CCC 993 (not published) Note: California Supreme Court granted review 10-24-01.

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The applicant was injured in the course of his employment with the State of California. After he returned to work his disability was declared permanent and stationary. He continued to receive medical treatment pursuant to an award. His doctor was only available during his work hours so he had to take time off work to seek treatment. His employer required him to deduct that time off work from accrued sick leave or from vacation time. Because the employer required him to deduct sick leave or vacation time rather than receive temporary disability indemnity for the time devoted to his treatment, he filed a claim for increased benefits under L. C. §132a arguing that such a forced deduction was discriminatory. The WCJ agreed and awarded increased benefits under L. C. §132a. The WCJ held that L. C. §4600 requires one day of Temporary Disability for each day of lost wages. In a 2 to 1 decision, the Board affirmed the decision even though Labor Code §4600 does not mention the payment of Temporary Disability for attending medical treatment. The Board cited AD Rule §10111.1(a)(4) which provides for a penalty to pay Temporary Disability for medical treatment. The defendant filed for review which was granted. On review the Court conducted a review as to when the employer is obligated to pay Temporary Disability. In reviewing L. C. §4600 the Court noted that the statute, among other things, provides for one day of Temporary Disability for each day of lost wages for a medical examination set on behalf of the defendant, the Board, or a WCJ. They found no language in Labor Code §4600 which confers a right to Temporary Disability on a person who has returned to work and whose disability is permanent and stationary. That right is limited only to medical-legal examinations. The court pointed out that in *Mead v. Diamond Intl. Corp.* (1974) 39 CCC 1 (en banc) the WCAB noted that "in compensation practice day in and day out employees are totally uncompensated for wages lost while attending to medical treatment during their work day. It has long been considered that in exchange for blanket coverage of compensation without regard to fault, the employee bears some of the burden." Therefore, when the applicant returned to work, he was no longer entitled to Temporary Disability because Labor Code §4600 limits the benefit only to examinations and not treatment. AD Rule §10111.1(a)(4) only applies where there is failure to pay Temporary Disability which is undisputed. Here there is a dispute. Furthermore,

an AD cannot confer a benefit where there is no statutory basis. Therefore, as a matter of law, a worker who is permanent and stationary and has returned to work and is receiving treatment is not entitled to Temporary Disability while absent from work.

Here, since the applicant failed to show he had a right to receive temporary disability and be reimbursed for the benefits that he was docked, he failed to meet his burden setting forth a prima facie showing of discrimination.

The court annulled the Board's decision.

X Medical Treatment / Presumption of Correctness of Primary Treating Physician

1 *Allen v. State Compensation Insurance Fund* (2001) 29 CWCR 156 (Board Panel Decision).

Applicant worked as a truck driver and injured his right elbow on December 10, 1999. The applicant continued working until the late spring of 2000 when he began receiving treatment including surgery for a neck and left arm condition. On November 27, 2000, the applicant filed two applications; one for a specific injury to his right elbow on December 10, 1999, and the other for a cumulative trauma injury to his neck and left arm arising out of his employment as a truck driver and heavy equipment hauler.

Not receiving an answer from the defendant by January 21, 2001, the applicant requested an expedited hearing. On February 21, 2001 State Compensation Insurance Fund wrote a letter accepting liability for the specific injury, but denied the cumulative trauma claim. On March 27, 2001, the day before the expedited hearing, SCIF filed an objection to the Declaration of Readiness to Proceed.

At the hearing on March 28, 2001, defendant renewed its objection to the proceeding. The Workers' Compensation Judge, observing that SCIF had neither filed an answer, nor submitted a timely objection to the Declaration of Readiness to Proceed, went ahead with the hearing. After hearing the evidence and refusing to hold the record open for a defense medical, the WCJ found the applicant sustained an injury to his neck and left arm, causing temporary disability and need for medical treatment. The Judge ordered the specific injury case off calendar.

State Compensation Insurance Fund filed a Petition for Reconsideration contending it was error to hold an expedited hearing when injury was at issue and refusing to hold the record open for their medical and other evidence.

The Workers' Compensation Appeals Board, in a two-to-one decision, concluded that the case should be returned to the trial level for further proceedings. The Board stated that, although the WCJ indicated he held the hearing because SCIF did

not file an answer and did not timely object to the Declaration of Readiness to Proceed, they were persuaded that this is not a sufficient reason to try the issue of injury arising out of and occurring in the course of employment at an expedited hearing, over objection. The Board concluded that a party cannot obtain an expedited hearing when injury is in dispute, citing the case of *David v. WCAB* (1998) 63 CCC 192 (writ denied) and *Herman v. WCAB* (1996) 61 CCC 369 (writ denied). The Board concluded that unreasonable delay may not be considered at an expedited hearing because it is not one of the issues listed in L. C. §5502(b) that authorizes the Administrative Director to establish a priority calendar for issues requiring an expedited hearing and decision. The issue of causation cannot be tried at an expedited hearing because it is not one of the issues specified in L. C. § 5502(b) or A.D. Rule §10136.

In a dissenting opinion, the dissent commissioner said that she would have affirmed the award because there was no evidence in the record that SCIF had timely denied the claim (the letter which SCIF wrote accepting liability on the specific and denying the cumulative trauma injury was not in the record), and SCIF had not timely objected to the Declaration of Readiness to Proceed. She distinguished the case of *David* because there the defendant objected to the Declaration of Readiness to Proceed and did not have 90 days to investigate as SCIF did in this case. The Commissioner stated that although the issue of injury is not specifically listed in L.C. §5502(b), it is difficult to believe the legislature intended to limit expedited hearings exclusively to admitted injury cases.

2 *Cardenas v. WCAB* (2001) 66 CCC 892 (writ denied).

Applicant suffered an admitted injury on March 17, 1998. Applicant treated with a William Simpson, MD. Defendants subsequently filed a petition for order requiring employee to select an employer-designated physician with the administrative director. Defendants alleged in their petition that Dr. Simpson was not properly reporting. The administrative director granted the petition for change of physician on March 3, 2000. Applicant appealed the administrative director's order to the WCJ on April 7, 2000. On April 19, 2000, applicant informed defendant that she was designating a new treating physician.

In a finding of fact, the WCJ found defendants' request for change of treating physician and the administrative director's order was rendered moot by applicant's change of treating physician while her appeal of the administrative director's order was pending.

The WCAB granted reconsideration and rescinded the WCJ's decision and dismissed the petition for removal as being moot. The WCAB held applicant's unilateral choice of a new treating physician, while her appeal was pending, violated Labor Code §4603 procedures. The Appeals Board indicated that L. C. §4603 provides that if the employer desires a change of physician or chiropractor, he may petition the administrative director, who, upon a showing of good cause by

the employer, may order the employer to provide a panel of five physicians or, if requested by the employee, four physicians and one chiropractor, competent to treat that particular case, from which the employee must select one.

The WCAB indicated that an employee who has not previously designated a treating physician is entitled to select a treating physician 30 days after the date of injury. However, an employer may petition to change physicians. When the employer has shown good cause for change of physician, L. C. §4603 sets forth the procedure to be followed, i.e., the furnishing by the employer of a panel from which the employer must select a new physician.

In this case defendants' request for change of physician was granted by the administrative director, and then applicant filed an appeal to the WCJ. During the pendency of the appeal, the applicant selected a new physician. The Board indicated they found this action contrary to the statutory scheme set forth in L. C. §4600 in the following sections. To allow the applicant to circumvent the procedures set forth in L. C. §4603, and to allow her to select a new physician on her own, during the appeal process which she initiated, would nullify defendants' right to regain control of medical treatment upon a showing of good cause and would render meaningless both the administrative director's decision and a portion of the statutory scheme.

Therefore, they concluded the applicant is not entitled to select a new physician outside the panel to be provided by the defendant, defendants having prevailed on its petition to change physicians.

The Board then went on to state they found no basis for reversing the administrative director's decision. Applicant had not shown that the doctor complied with the reporting requirements nor did they contend so. The applicant has not argued that she wishes to continue under Dr. Simpson's care. Rather, the applicant relies, instead, on her circumvention of the statute to allow her to select a new physician of her choice.

The Board then indicated that they did not find she is entitled to do a change of physician at the time of appeal. The Board went on to note, however, that defendant conceives, in its petition, that after reasonable time, applicant may again select a different physician if she wishes. The Board then indicated in their decision after reconsideration they will deny applicant's appeal of the administrator director's decision. The parties could now proceed with the selection of a new physician under L.C. §4600. The writ of review was denied.

3 *Hines v. New United Motors* (2001) 66 CCC 478, 29 CWCR 105(Board En Banc).

The applicant sustained a back injury on August 18, 1998. The applicant initially treated with Dr. Nassiri whose office is in Saratoga. On June 14, 2000, Dr. Nassiri

reported that the applicant's disability was permanent and stationary. The doctor noted that the applicant was moving to Santa Maria and should continue to treat there on an as-needed basis for any flare-ups. Two weeks later the applicant sought treatment with Dr. Bernfeld in Santa Maria.

On July 20, 2000 the parties submitted stipulations which provided for medical treatment for the applicant's back injury. It was a general stipulation.

On August 3, 2000 the defendant sent a letter to Dr. Bernfeld objecting to his treatment as being excessive and exceeding the recommendations of Dr. Nassiri.

On August 8, 2000 Dr. Bernfeld again treated the applicant for a severe flare-up, and he recommended further extensive active treatment. On August 23, 2000, the defendant advised that it would not authorize this new regimen of treatment, as it was not the treatment contemplated by the treating doctor, Nassiri.

The applicant requested an expedited hearing which took place on September 22, 2000, where it was noted that the applicant selected Dr. Bernfeld as his primary treating physician. The case was submitted on the sole issue of whether the treatment provided by Dr. Bernfeld was related to the original back injury or whether it was necessitated by a non-industrial flare-up. The WCJ found that the applicant was entitled to the further treatment recommended by the newly selected treatment physician.

The defendant sought reconsideration on the basis that the applicant was obligated to return to the original treating physician and was not entitled to a new treater under Rule §9785(b) without first complying with L.C. §§4061 and 4062.

Rule §9785(b) requires that no other primary treating physician shall be identified unless and until the dispute is resolved.

The Court held that once there is an existing award for medical treatment, the applicant is entitled to reasonable changes of treating physicians without the necessity of following the procedures set forth in L.C. §§4061 and 4062. The applicant may exercise his right to a free choice of physician within the scope of L.C. §4600, subject to the standard of reasonableness.

When continuing medical treatment has been awarded Rule §9785 (b) is no longer applicable. The stipulated award resolved any dispute over need for treatment when the parties stipulated that there was a need. As to whether Dr. Bernfeld's treatment being reasonable and necessary, the Board states they found no evidence to the contrary and thus awarded it.

The Board affirmed the WCJ's decision.

4. *Holland V. WCAB* (2001) 66 CCC 1279.

The applicant sustained a finger injury in September 1998. He was treated by Dr. Macer who gave him a verbal release from further case in July, 1999.

On July 27, 1999 Dr. Macer wrote a report that the applicant was released with no resultant permanent disability. The claims adjuster advised the applicant of his right to a panel QME, but when the adjuster did not send him a copy of Dr. Macer's report he cancelled the QME exam and sought legal counsel. The applicant's attorney wrote a letter to the defendant demanding a copy of the Macer report and advised the defendant that the applicant was selecting Dr. Sobol as treating physician. Dr. Sobol treated the applicant from January 11 to February 25, 2000. On April 6 the defendant served the Macer report. On April 15 the applicant's attorney objected to Macer's opinion.

At trial the applicant admitted that he had been released by Dr. Macer. The WCJ issued a decision based upon Dr. Macer's opinion and he ruled that the reports of Dr. Sobol were inadmissible. Applying *Tenet/Centinela Hosp. Med. Ctr. V. WCAB (Rushing)* (2000) 65 ccc 477, the WCJ found that the applicant was aware that Dr. Macer had released him at the time he selected a new treating physician. Since there was no objection at that time, then Dr. Macer remained the primary treating physician whose opinion is entitled to the presumption of correctness under L.C. §4062.9.

The Appeals Board denied reconsideration and the applicant filed a petition for writ of review.

The appeals court pointed out that a worker is entitled to change treating physicians, but there are some limitations. There can be only one primary treating physician at a time. When a PTP discharges a worker from treatment, under AD Rule §9785(b) no other PTP can be selected until any dispute over further treatment is resolved in accordance with L.C. §4062.

Here the applicant was unrepresented when discharged from care. He then chose a QME, but cancelled it when he did not receive a copy of Dr. Macer's report. He was then required to complete the L.C. §4062 procedure before he could select a new PTP. He failed to do so. Therefore, Dr. Sobol was not a PTP and his reports were properly excluded.

The failure to receive the report of Dr. Macer had no effect here. The applicant knew he was discharged and had already selected a QME from a panel before he attempted to select Dr. Sobol as a new PTP.

The court affirmed the Board's decision.

5. *Ordorica v. Workers' Compensation Appeals Board* (2001) 66 CCC 333.

Applicant claimed he injured his head, neck, back, both upper extremities and his psyche arising out of and occurring in the course of employment on February 4, 1999. The defendant referred the applicant to Daniel Mongiano, M.D. who diagnosed a wound to the forehead which required sutures. The applicant claimed he told the doctor he had injured his neck and back as well, but the doctor found the complaints unrelated. Pursuant to company policy, the doctor also conducted a drug test, which was positive for marijuana. Applicant returned to the doctor to have the stitches removed, but he doctor was not in. The applicant informed the receptionist he had to leave to pay some bills and was told the doctor would be in the office when he returned. When the applicant returned, the office was closed. The applicant removed the stitches himself.

On February 20, 1999, the applicant retained an attorney. In a letter dated February 22, 1999, the attorney wrote the defendant that he was representing the applicant who was unhappy with his present medical care and was making a demand for change of physician within five days. In a separate letter, the applicant's attorney stated that the applicant had chosen Ronald Perelman, M.D. as his primary treating physician pursuant to L. C. §§4600 and 4601. In a third letter, the applicant's attorney confirmed an appointment had been set with Dr. Perelman for March 5, 1999. By letter of February 25, 1999, the defendant faxed applicant's attorney, acknowledging receipt of the February 23, 1999 fax, and gave notice that the defendant designated G.B. Ha'Eri, M.D. as the new primary treating doctor, and an appointment had been scheduled for the applicant for March 2, 1999. In a separate letter dated the same date, the defendant asked whether applicant would attend the appointment with Dr. Ha'Eri since the applicant's attorney had indicated that he was selecting Dr. Perelman as the primary treating doctor. The defendant further stated that medical control of treatment within the first 30 day period continued by providing the appointment with the new doctor within five days, and attendance was mandatory.

Dr. Mongiano issued a report signed on February 26, 1999 with a copy to Dr. Ha'Eri that the applicant was declared permanent and stationary and released from further medical care because he had not returned for treatment. The applicant failed to attend the March 2, 1999 appointment with Ha'Eri. The defendant then informed the applicant his claim was denied. On March 5, 1999, the applicant initiated treatment with Dr. Perelman which included therapy to the spine. The applicant was finally evaluated by Dr. Ha'Eri on June 21, 1999. The doctor diagnosed a concussion and forehead laceration which had been sutured and healed. The doctor concluded the applicant was permanent and stationary with no residual disability and required no restrictions or future medical care. In his deposition, applicant testified that he never received notice of the March 2, 1999 appointment with Dr. Ha'Eri. When the applicant subsequently received the denial letter from defendant, applicant called his attorney and was told "I didn't want you to go to that doctor. You're going to my doctor." At trial, defendant admitted injury to the head, but denied the upper extremities, neck, back and psyche. The issues submitted for decision were limited to whether applicant could designate Dr.

Perelman as the primary treating doctor or was estopped, and deposition attorney fees. At trial, the applicant testified he was advised he did not have to go to Dr. Ha'Eri for treatment, and can choose to wait and see Dr. Perelman three days later. The applicant added he lost confidence in the company doctors because he was denied back treatment, the stitches were not removed and he was tested for drugs although he did not cause the accident.

The WCJ found the applicant's failure to keep the March 2, 1999 appointment with Dr. Ha'Eri was in *bad faith*, and an illegal attempt to deny defendant's right to control medical treatment during the first 30 days following the injury. Consequently, the applicant was estopped to declare Dr. Perelman as the primary treating physician and defendant's right to control was extended until two days following an examination to be scheduled by Dr. Ha'Eri. The WCJ also denied deposition attorney fees. In his *Opinion on Decision*, the WCJ explained that the applicant and his attorney were informed by defendants they were maintaining their medical control of treatment with the appointment with Dr. Ha'Eri. In addition, the record showed that applicant's attorney intended to secure the right before the 30 day period expired as indicated by the appointment being set with Dr. Perelman. As a result, the WCJ concluded that Dr. Ha'Eri remained the primary treating physician. Applicant filed a Petition for Reconsideration. The applicant, in his petition, alleged that any interference with defendant's right of medical control within the first 30 days was inadvertent. Applicant claimed the appointment with Dr. Perelman was mistakenly set within the 30 day period because it was overlooked that February contained only 28 days and March 5th was actually a 29th day. Applicant's attorney further argued that legal alternatives are self-treatment, paying for alternative treatment or waiting for the employer's period of medical control to expire. The applicant's attorney argued that trial testimony confirmed there were good reasons to avoid treatment with defendant's physicians therefore the applicant decided to wait and see Dr. Perelman. The attorney argued that even if missing the initial appointment with Dr. Ha'Eri was used as a deliberate deprival of defendant's right to medical control, there was no authority for rejecting applicant's choice of Dr. Perelman or to extend defendant's right of control indefinitely. The WCJ, in his *Report on Reconsideration*, indicated the right to control during the first 30 days is well established under L. C. §§4600 and 4601. The WCJ reasoned that although the defendant had timely arranged for an appointment with Dr. Ha'Eri under L. C. §4601, which was still within the first 30 days of medical control under §4600, all of which was communicated to applicant's counsel, nevertheless the applicant's counsel arranged treatment with Dr. Perelman during the 30 day period. The WCJ also concluded that the attorney's claim in the Petition for Reconsideration that no instructions were given to disregard the appointment with Dr. Ha'Eri was not evidence. The judge noted that under L. C. §*9785 (b)*, there can be only one primary treatment doctor at a time. Since applicant had not been released by the new primary treating doctor designated by defendant, and, in order to restore the parties to status quo ante, applicant was estopped from designating Dr. Perelman as primary treating doctor, and employer control over medical treatment was extended two days beyond the

examination of Dr. Ha'Eri. In a 2 to 1 decision, the WCJ was upheld by the Appeals Board, and reconsideration was denied. The majority found that regardless of the applicant's attorney's advice, the appointment with Dr. Ha'Eri was mandatory even though the treatment could be rejected. In addition, based on the evidence which did not include the applicant attorney's testimony, applicant's refusal was deliberate.

The Court of Appeal concluded that the defendant exercised medical control treatment following the industrial injury. The applicant challenged the treatment under L. C. §4600 allegedly for not providing back treatment or removal of the stitches, and for requiring drug testing. The Court stated that when proper treatment for an industrial injury is not provided by the employer during the medical control, the injured worker can self-procure and seek reimbursement. However, the WCJ and the WCAB majority here determined this was not the actual basis for the applicant's change of physicians. Instead, the applicant's actions were viewed as a deliberate attempt to deny defendant's legitimate right of medical control in order to gain legal advantage, that is the presumption of correctness under L.C. §4062.9. The Court concluded that substantial evidence exists to support the judge's and the Board's conclusion. Applying these facts to the law, the court went on to state that the applicant alleged that L. C. §§4600 and 4601 were not violated because he was not legally obligated to accept treatment tendered by the defendant or attend the appointment with Dr. Ha'Eri.

Applicant further contends that he has the option of caring for himself, paying for the treatment or waiting until the 30 day period of employer medical control has passed. If an injured worker reasonably declines treatment provided by employer, the right to receive further compensation remain. Conversely, compensation is not payable when disability is caused, continued or aggravated by an unreasonable refusal to submit to treatment.

It appears the law does allow an injured worker certain choices with regards to medical treatment, which arguably support applicant's claim that he was advised as stated at trial. However, in this case Dr. Perelman provided treatment, payment is not an issue, and applicant did not wait until defendant's medical control expired. Instead, applicant began treatment with Dr. Perelman during the 30 day prohibited period, whether intentional or otherwise. Liberal construction of the law does not change the result. Had applicant waited and not infringed on defendant's right of control, the outcome may have been different. Further, applicant asked for a change of physician, but the request was determined to be legal subterfuge.

The Court went on to indicate that the WCJ and the WCAB majority apparently attempted to apply equitable estoppel in fashioning relief. The Court concluded from the facts of this case that estoppel has not been established as a remedy. The Court then went on to state, however, that does not mean that the defendant was without remedy. Medical control remained with defendant when applicant illegally

attempted to select Dr. Perelman as his primary treating doctor and treatment began. There can be only one primary treating doctor at a time. Dr. Ha'Eri retained the primary treating doctor status. That status as a primary treating doctor continued until the applicant was discharged. Therefore, Dr. Pearlman never became the primary treating doctor pursuant to law. The case of *Tenet* held, in part, that the primary treating physician status is retained when another primary treating physician is designated after discharge from treatment contrary to the statutory scheme set forth in L. C. §§4060 and 9785(b). Thus the applicant is obligated to follow the procedures set forth in Labor Code §4060, et seq. In the Court's opinion, this is just because it was determined that the applicant attempted to manipulate the statutory scheme. The Court went on to state that nothing in their opinion precludes applicant from seeking a determination whether the procedures under L. C. §4060 et seq. were followed after the discharge by Dr. Ha'Eri, or whether such procedures can still be initiated. They express no opinion regarding the outcome should the applicant so proceed. The WCAB's decision that applicant violated L. C. §§4600 and 4601 is affirmed.

The WCAB's decision as to the remedy is reversed. The matter is remanded for further proceedings consistent with this decision.

6. *Pinkerton v. WCAB (Samuel)* (2001) 66 CCC 695.

The applicant was employed as a security guard by Pinkerton. She was injured at work. She injured her back, neck, shoulder, right wrist, right knee and both ankles. The defendant prepared a pre-printed document entitled "Notice to Doctor" to refer the applicant to Santa Monica Bay Physicians. The first line stated: "To: Treating Doctor (PTP)." No physician was named or otherwise identified. The next day the applicant saw Dr. Chris Effimoff of Santa Monica Bay Physicians. The doctor entitled his report "Doctor's First Report of Injury." The applicant was directed to return in three days for further evaluation to determine whether she needed physical therapy.

On May 1, and May 12 the applicant received further treatment from Santa Monica Bay Physicians, this time from a different physician. She was not discharged from treatment by Dr. Effimoff, and his report was not served on the applicant.

Applicant retained an attorney. On May 15, 1998, within 30 days of the injury, the attorney sent a letter of representation to Pinkerton asking for a change of treating physician to Westside Wilshire Medical Group, pursuant to L.C. §4600 or 4601, as applicable. A week later, on May 22, 1998, Pinkerton prepared a pre-printed "Notice to Doctor" for an appointment at U.S. Healthworks. This form was similar to the notice to doctor that referred the applicant to Santa Monica Bay Physicians. The notice did not indicate whether it was an appointment in response to Samuel's request for a change in treating physician. The form did not expressly specify any person or entity as a recipient. The form bears the signature of a

Pinkerton supervisor and the same date as the applicant's appointment at U.S. Healthworks. At some point, applicant became aware of the appointment.

Applicant was examined by Dr. Mark Newman at U.S. Healthworks on May 22. In his report, based on that examination entitled, "Doctor's First Report of Occupational Injury or Illness," Dr. Newman found applicant's complaints grossly embellished and that she was permanent and stationary. He discharged her from further treatment and stated she could return to work without restriction. Nevertheless applicant was examined by Dr. Newman a week later. In a report dated July 5, 1998 entitled, "Primary Treating Physician's Permanent and Stationary Report," Dr. Newman reiterated that the applicant had been discharged from treatment on May 22 and 29 and could return to full duties. He found that she had no permanent disability. Neither the first, nor the follow up report of Dr. Newman was served on applicant's attorney until July 9, 1998, a date subsequent to her examination by a physician she selected, Dr. Lana Geyber.

In a letter to the applicant dated May 28, 1998, the Pinkerton Claims Administrator informed the applicant that she could object to Dr. Newman's finding and was entitled to obtain an expert medical evaluation from a qualified medical examiner. Dr. Newman's report of May 22, 1998 purportedly was attached to that letter. The letter and the attached report were not served on applicant's attorney of record. In mid-June 1998, the applicant was telephoned and informed that Dr. Newman had discharged her from treatment, and that she needed to obtain an expert evaluation. A message was left with the applicant's attorney informing him of the need to attempt to agree on an AME in the event applicant intended to object to Dr. Newman's decision.

On June 15, 1998, the applicant was examined by Dr. Geyber of Westside Wilshire Medical Group, the provider she had selected. The doctor recommended the applicant be treated with muscle relaxing medication, physical therapy, and an ankle brace. On June 25, 1998, Dr. Geyber served her report of June 15, 1998, entitled "Initial Primary Treating Physician's Examination Report" on both the defendant and on applicant's attorney. On June 30, 1998, applicant's attorney served Dr. Geyber's report on the defendant. In September 1998 Dr. Geyber referred applicant to Drs. Ferman and Baybrook, respectively, for neurological and orthopedic consultations. In December 1998, Dr. Geyber referred the applicant to Dr. Habibi, a neurosurgeon, to evaluate for surgery. Dr. Habibi performed surgery in January 1999.

A hearing was held in November 1998, to determine whether the continuing medical treatment was necessary and to determine the primary treating physician. Applicant was the only witness. At the hearing the defendant objected to any evidence from Dr. Geyber because it claimed Dr. Newman was the primary treating physician. The applicant argued that Dr. Geyber was the primary treating physician. Each party claimed the other failed to comply with the objection requirements of L. C. §4061. The issue of whether the initial appointment with

Dr. Newman was in response to the applicant's request for change of treating physician was not raised.

The Judge found Dr. Geyber was the primary treating physician and that Dr. Newman's discharge of applicant from treatment had no effect. The Judge also found that, because applicant needed further treatment, L.C. §4061 was moot.

The Appeals Board granted defendant's petition for reconsideration. The defendant asserted it had referred the applicant to Dr. Newman in response to applicant's request for a new treating physician. The defendant pointed out that applicant attended the appointment and argued that it complied with the service and identification requirements for the primary treating physician contained in former Rule §9785.5(b). The Board found that it was not clear that defendant had referred applicant to Dr. Newman in response to her request for change of treating physician. The Board found that neither party complied with the requirements of §9785.5(b). In the defendant's case, because the "PTP" designation it had inserted before Dr. Effimoff's name was insufficient identification, and it was not clear that Dr. Effimoff's report had been served on the applicant. Additionally, neither the "Notice to Doctor" referring applicant to U.S. Healthworks, nor Dr. Newman's "First Report of Injury" identified Dr. Newman as the primary treating physician. Applicant had not complied, because it was not clear that defendant had been served with Dr. Geyber's report. The matter was remanded to the judge to determine whether Dr. Effimoff was the primary treating physician.

On July 7, 1999 Dr. Geyber declared applicant permanent and stationary and determined there was no need for immediate further treatment, but provided for future treatment as needed. Dr. Geyber also found significant permanent disability.

Following a new hearing in late July 1999, the judge again found Dr. Geyber was the primary treating physician and that Dr. Effimoff was not, because he had not complied with Rule §9785.5(b) in that he had failed to identify himself as the primary physician and serve his report. The Board also found that Dr. Newman was not the primary physician. The Board concluded that the defendant's letter and the report of the doctor did not identify Dr. Newman as the primary physician, nor had the report been served on applicant's attorney. No evidence was presented on the issue of whether the referral to Dr. Newman was in response to applicant's request for a change of physician. The WCJ made no finding on that issue.

The defendant again petitioned for reconsideration. The Board denied the new petition and adopted the judge's report as its own decision. In his report, the judge explained that Dr. Effimoff did not qualify as the primary treating physician under Rule §9785.5(b) because his report had not been served on the applicant. Dr. Newman was not the primary physician because he did not identify himself as such in his report of July 5, 1999, a date after Dr. Geyber already had taken

control. The WCJ also explained the applicant was not estopped from denying that Dr. Newman was the treating physician because defendant had failed to notify her that its reference to the physician was in response to a request for a change of physician. As a result, the WCJ concluded the applicant was entitled to select a treating physician of her choice and did select Dr. Geyber. The WCJ found that Dr. Geyber's June 15, 1998 report had been properly served and that Dr. Geyber identified herself as the primary physician, thereby becoming the primary treating physician. The WCJ further found that defendant waived any objection to Dr. Geyber's report as the primary treating physician because they had not objected to the admission of the report.

Defendant contended on Writ of Review that Dr. Newman was applicant's primary treating physician because Dr. Newman was supplied at applicant's request for change of physician. The Court concluded that contention was not supported by the record.

L.C. §4061 establishes the right of the employee to request a change of treating physician and simply requires the employer to provide the employee an alternative physician within 5 working days from the date of the request. The regulation, however, requires the employer to respond promptly and in the manner best calculated to reach the employee and in no event later than 5 working days from receipt of the request. The regulation provides the employer shall advise the employee with the name and address of the alternative physician, the date, time of initial appointment and any other pertinent information. The employer may confirm its response in writing. The defendant argues that it complied with the notification requirement and that the notice was sufficient because the applicant did appear within the 5 day period and was examined by Dr. Newman. The WCJ found that defendant did not provide Dr. Newman in response to applicant's request for a change of physician. The defendant's "Notice to Doctor" does not satisfy the requirements of L.C. §4601 and Rule §9781. It was addressed to an unnamed physician. Since no recipient was designated, it is not clear to whom the notice was to be provided. The notice purports to send the applicant to an unidentified PTP.

Most important, the notice says nothing about being in response to applicant's request for change of treating physician. At most, it is a direction that the applicant report to a healthcare facility. On this record the judge properly concluded that Dr. Newman was not provided in response to applicant's request for change of physician, and applicant was entitled to treatment from a physician of her own choosing.

At oral argument, for the first time defendant argued that L.C. §4601 does not provide procedural guidelines for notification of the change of treating physician. As a result, it argued any new treating physician to whom the applicant is referred within the 5 day limitation satisfies the new requirement of L.C. §4601. Defendant did not raise this issue before, and therefore, it not entitled to pursue it on appeal.

Even if the point were made, it would not succeed. L.C. §4601 does not set out any procedural requirements, but §9781 requires the employer to respond promptly in the manner best calculated to reach the employee. Considerations of fairness and efficiency dictate that the better practice is to serve the employee with the notice, and if the employee is represented, the notice should be served on the employee's representative. Good practice is not necessarily compelled practice. But since designation of the primary treating physician is a matter of substantial legal significance in the development of the case, the notice must make it clear that the designated alternative physician is the primary treating physician. It did not and is, therefore, deficient.

Defendant further contends that applicant was foreclosed from obtaining further treatment because she did not object to Dr. Newman's report and obtain rebuttal. First, no objection or rebuttal was necessary because Dr. Newman was not the applicant's primary treating physician. L.C. §4061 makes it clear these steps are invoked only in response to a report from a primary treating physician.

The WCJ found that Dr. Newman was not the primary treating physician because Dr. Geyber had taken control before Dr. Newman identified himself as the primary treating physician, and Dr. Newman's report was not served on applicant's attorney who was retained prior to the doctor's initial examination. The WCJ, the Board and the parties focused their principal dispute over whether the primary treating physician must identify himself or herself as such. The defendant argues that the treating physician is not required to say that he or she is the primary treating physician. The governing statutes and regulations are ambiguous on this point. But the Board has consistently concluded in opinions that such identification is required. The Board also concluded the primary treating report must be served on the employee. The case is not decided on whether service on the employee's attorney is required. The Board relies on its interpretation of former Rule §9785.5(b) which states when the primary treating physician has been selected by the employer…the primary treating physician shall be identified in a report to the employer and to the employee or the employee's representative. The plain language of the regulation does not address how the primary treating physician is to be identified and particularly whether the person must state his or her name and qualifications or that he or she is the primary treating physician or both. Related statutes and regulations are of little assistance. They do no more than indicate that the term primary treating physician is administrative shorthand for describing the physician who is primarily responsible for the injured worker's treatment. The regulation also is ambiguous as to whether service of the primary treating physician report on the attorney or represented employee is required because of the disjunctive word "or." However, L.C. §4061 and 4062, which specify different times in which represented and unrepresented employees may object to the primary treating physician's report seem to require service of the report on a represented employee's attorney. Thus, even according proper weight to the Board rules, they are not sufficiently clear to be dispositive of the issue. The Board may wish to consider amending its regulation to say what they mean.

Tenet/Centinela Hospital Medical Center is not controlling. In that case the Court concluded that the medical report terminating treatment was properly served on the unrepresented employee long before she obtained an attorney and began further medical treatment with a new physician. That did not occur here. The defendant argues that the applicant should be estopped from denying that Dr. Newman is the primary treating physician because she knew Dr. Newman had discharged her from treatment before she retained counsel. The record refutes this assertion. On May 15, 1998, applicant's attorney sent defendant a letter of representation. Dr. Newman did not discharge applicant until May 22, 1998. Defendant contends Dr. Geyber's reports are inadmissible under L.C. §4628 because the doctor failed to review the reports of Drs. Effimoff and Newman, but L.C. §4628 only applies to medical-legal evaluators.

Alternatively, defendant argues that the reports are inadmissible because Dr. Geyber did not comply with the review requirements of Rule §9785. At oral argument, however, defendant conceded that such noncompliance would not render the reports inadmissible. Its concession is well founded. Failure to review prior treatment records may affect the weight given to the primary treating physician's opinion, but does not render the physician's treating report inadmissible.

Defendant contends that Dr. Geyber's report does not constitute substantial evidence on any issue related to applicant's medical condition. For support, it relies on the fact that Drs. Effimoff, Newman and Wilson, the defense expert medical evaluator in the third party civil litigation action, as well as Dr. Pearl, applicant's personal physician, all arrived at conclusions different from those reached by Dr. Geyber. The Court pointed out that the relevant and considered opinion of a single physician, although inconsistent with other medical opinions, generally constitutes substantial evidence. An exception arises if medical reports and opinion are based on surmise, speculation, or conjecture, or if they are known to be erroneous or based on inadequate medical histories and examinations. No such deficiencies are demonstrated in this case.

7. *The May Company Department Stores v. WCAB (Vallejo)* (2001) 66 CCC 1381 (writ denied).

Applicant, a warehouse worker, claimed two industrial injuries, one, a specific injury on 9-19-98 to his back, shoulders, and headaches and neck, and, two, a CT injury from 8-25-93 to 8-3-98 to his back, shoulders, headaches and neck.

The WCJ found the specific injury AOE/COE to applicant's neck and back only and found no CT injury on the dates claimed. The WCJ decided not to award permanent disability based on reports from applicant's treating physician. Dr. Wood, applicant's treating physician, would have rated 44 percent. The WCJ instead relied on the range of evidence and awarded 16 percent permanent disability for the specific injury and a need for medical treatment for the back and neck.

The WCJ further found the L.C. §4062.9 treating physician presumption, did not apply to reports from the applicant's treater, Dr. Wood, for the specific injury.

Applicant filed a petition for reconsideration contending the presumption applied to Dr. Wood's reports; Dr. Wood's reports were substantial evidence to support the findings of a specific and CT injuries: and the surveillance videotape of applicant's activities did not overcome the treating doctor presumption.

The WCJ's report and recommendation denying reconsideration indicated that the treating physician presumption did not apply to applicant's CT claim because defendants denied the CT injury to all body parts claimed. The WCJ found the presumption applied only to the specific injury and the body parts admitted by the defendant for that injury, neck and back. The WCJ found the presumption was overcome by a preponderance of medical evidence that indicated a level of impairment different from that stated by the treater.

The WCJ also stated the applicant was not found to be credible on the witness stand as to his current subjective complaints and physical limitations or to injury AOE/COE for the alleged specific injury and CT injury.

The WCAB granted reconsideration and rescinded the WCJ's decision and instituted a new F&A. The WCAB found the specific injury AOE/COE to applicant's neck and back on 9-19-1998. The WCAB also found the CT injury AOE/COE on the dates claimed to applicant's neck and shoulders but not to his back or headaches. The WCAB found applicant was entitled to a permanent disability award of 44 percent for the two claimed injuries.

The WCAB, in discussing the treating doctor presumption, found that after reviewing the video films, they were convinced that the WCJ's decision should be reversed since they disagreed with his assessment of the video films and his opinion that the presumption of correctness of the treating physician did not apply to body parts denied by the defendant as to the specific injury of 9-19-98.

The WCJ did not find applicant credible, largely on the basis of the filmed activity. Given the Board's assessment of the filmed activity, they declined to follow the WCJ's opinion as to applicant's credibility. The Board is entitled to reject the WCJ's findings on credibility matters where substantial evidence supports a contrary finding (*Garza v. WCAB* (1970) 35 CCC 500.) Evidence of considerable substantiality supports the Board's conclusion. The filmed activity, in their opinion, is not inconsistent with applicant's testimony or the restrictions described by Dr. Wood.

Dr. Wood reviewed the videotape in question and concluded that the filmed activities showed essentially minimal effort, though applicant did squat and bend over once or twice. Dr. Wood, in his report, indicated the video shed very little

light on applicant's overall picture and it did not change his opinion previously outlined. The doctor recommended prophylactic preclusions, and the filmed activity was not inconsistent with those preclusions.

The Board further concluded that the presumption of correctness of the treating physician would apply to the parts injured in the specific injury, parts both admitted and denied. The presumption has not been rebutted under L.C. §4062.9. L.C. §4062.9 expressly refers to comprehensive medical evaluations obtained under L.C. §§4061 or 4062 which applies to accepted industrial injuries. Disputed industrial injuries fall under L.C. §4060. However, L.C. §4060 does not apply where injury to any part or parts of the body is accepted as compensable.

In the instance case, defendants admitted industrial injury to the neck and back, but denied the claimed injury to shoulders and headaches while applicant was employed on September 19, 1998. Accordingly, the presumption of correctness would apply as to all body parts involved in the specific injury.

The WCJ correctly found that the presumption did not apply to the claimed cumulative injury since defendant denied injury to all parts of the body claimed. Nevertheless, the Board found there was a cumulative injury to the neck and shoulders based on the medical opinion of Dr. Wood and the unrebutted testimony of the applicant. In their opinion, the applicant worked in a furniture warehouse and did very heavy work. The medical records from early 1998 supported the finding of a cumulative injury. The applicant was obviously having problems, and there is no evidence in the Board's opinion of causation other than work.

The Board then went on to find permanent disability based upon the medical opinions of Dr. Wood, whose opinions they accorded the presumption of correctness. They issued a combined permanent disability award of 44 percent.

Defendant filed a writ of review, which was denied.

8. *Turi v. United Airlines* (2001) 29 CWCR 126 (Board Panel Decision).

Applicant injured his back in the course of his employment as a mechanic. Liability was accepted, and the applicant had a spinal fusion. In the course of the surgery applicant's left common iliac artery was lacerated. A graft repair of the artery left the applicant afflicted with retrograde ejaculation. Applicant was told that he could become a parent only by sperm extraction followed by in vitro fertilization of his spouse. The parties stipulated to all issues including a 41 percent permanent disability and future medical treatment.

The only issue submitted to the judge was the reasonableness and necessity for in vitro fertilization. The parties stipulated to the facts, which were that the applicant and his wife had one biological child and they intended and desired to have more children. The applicant had been advised by his doctors that the only

method whereby he and his wife could conceive is through sperm retrieval from the gonads, followed by in vitro fertilization.

On April 20, 2000, the WCJ filed a finding of fact to the effect that the in vitro fertilization procedure was not reasonably required to cure or relieve from the effects of applicant's injury. Applicant petitioned for reconsideration contending that in vitro fertilization was the only means medically recommended to cure or relieve from the effects of the applicant's injury and the undisputed medical evidence established that in vitro fertilization was the only way applicant could become a parent and there was no evidence of cost factors or risk factors of failure that justified denial. Reconsideration was granted for the Board to study the issues.

After studying the issues, the Board concluded that pursuant to Labor Code § 4600, the employer had the duty to provide all care reasonably required to relieve from the effects of the injury. This could include treatment of nonindustrial conditions if necessary to cure or relieve from the effects of the industrial injury. Labor Code § 4600 has been liberally interpreted in favor of an injured worker's right to compensation. Housekeeping services and specially modified vehicles have been held to be the liability of the employer when medically necessary to cure or relieve the effects of the injury.

The panel cited the case of *Kennedy v. Argonaut Ins. Co.* 25 CWCR 243 (1992), which held that where an injured worker was about to undergo surgery that carried a 1 to 4 percent chance of causing retrograde ejaculation it was reasonable to award reimbursement of the cost of a preoperative sperm donation to enable the worker to have a child in the event that infertility resulted from the surgery. The sperm donation procedure was reasonably required to cure or relieve from the effects of the injury because it was the only safeguard against the risk of infertility. The risk was directly associated with the injury.

The Board indicated that *Kennedy* was applicable to the facts of this case. Although the applicant had not avoided the risk by making a preoperative sperm donation, the sperm extraction procedure was still available to him. Before the surgery the applicant had the ability to impregnate his wife, but there was no guarantee that she would become pregnant. Because he no longer had that ability, as a consequence of his injury, he was entitled to the sperm extraction as a reasonable means of relieving from that effect of his injury.

The Board then turned to the question of defendant's liability to provide in vitro fertilization. The panel indicated that this was not covered under L.C. §4600. The cost of the extraction of the eggs of the wife, who was not the injured worker, and inserting them in her womb after fertilization or any other procedure relating to pregnancy or child birth was not the liability of the defendant under L. C. §4600. It was no more certain that applicant 's wife would become pregnant from in vitro fertilization than it was before the injury.

Accordingly, in its decision after reconsideration, the panel amended the WCJ's finding of fact to provide that the sperm extraction was reasonably required to relieve from the effects of the injury, but the in vitro fertilization was not.

XI Medical Legal, QME Process & Other Discovery

1. *Lineback v. WCAB (Williams)* (2001) 66 CCC 772 (writ denied).

Applicant underwent a medical legal evaluation by Dr. James Lineback in May 1998. Dr. Lineback submitted a report dated June 22, 1008, and subsequently reviewed material safety data sheets and issued an 18 page supplemental report. He alleged he had spent seven hours reviewing the material safety data sheets and preparing the supplemental report. Defendant sought Dr. Lineback's deposition, and had difficulty in arranging a time and place for the deposition. Eventually, defendant sought an order directing that Dr. Lineback submit to deposition during regular business hours or have his reports excluded from evidence. An order directing deposition issued. Defendant set (and then changed location of the deposition) and advanced fees. The deposition was then postponed a month. On the date of deposition, Dr. Lineback arrived 30 minutes late and refused to proceed with the deposition. The WCJ ordered Dr. Lineback to appear for hearing, and when he failed to appear, excluded his reports from evidence. Defendant then sought restitution, costs, and sanctions. The WCJ then ordered restitution of all fees, including the deposition fee, paid by defendants, together with defendant's costs for their appearance at the San Francisco deposition. Dr. Lineback sought reconsideration. The Board adopted the WCJ's report and recommendation which noted the efforts made to arrange the deposition and the apparently deliberate refusal to proceed with the deposition.

2. *McCabe v. Fremont Comp Insurance* (2001) 29 CWCR 223 (Board Panel Decision).

On May 15, 1998, an applicant filed an application alleging that she had sustained a cumulative injury to her spine and arms during a five-year period. The defendant had the applicant evaluated by a doctor who stated in his report that the applicant appeared to have developed a psychological disorder, her physical condition has been influenced by psychological factors, and her physical disability might have a significant psychogenic component. He recommended a psychiatric evaluation.

Applicant's treating physician referred her to a psychologist, who opined that the applicant was depressed and in need of pain management psychotherapy. Applicant had her deposition taken. At her deposition applicant answered one question about her pain medication, but her attorney instructed her not to answer

the follow-up question about any other prescribed medication she was taking. The deposition ended without further testimony.

The defendant moved for an order directing applicant to answer the deposition questions. The motion and a counter-motion were heard at a mandatory settlement conference. At the MSC it was stipulated that applicant sustained an orthopedic injury, as alleged, and the discovery issues were submitted for decision.

Two weeks later the WCJ ruled that the defendant was entitled to question the applicant about: one, her prior medical history with respect to the arms and spine, plus the psyche; two, medication taken for these body parts; three, past history of symptoms in these parts; four, past treatment for them; five, to the extent that psychiatric problems can cause symptoms in other parts, questions in this area will be allowed.

Applicant filed a petition for removal arguing that she was not claiming any psychiatric injury and that she didn't have to answer these questions based on the doctor-patient privilege and right to privacy. In a two-to-one decision, the panel found merit in applicant's petition. The majority first indicated that although the WCAB is not bound by the common law or statutory rules of evidence, statutory privileges must be respected, not only in hearings, but also in discovery. An applicant for workers' compensation, however, waives these privileges as to medical conditions directly relevant to any issue tendered by the applicant in the proceeding. The question for decision, then, was what constitutes a directly relevant medical condition.

In the cases where the claimant is not asking for benefits for a psychiatric or emotional disorder, discovery of privileged information may not be permitted when based on mere speculation that there may be a connection between the claimant's past psychiatric treatment and some mental component of the injury at issue. *Roberts v. Superior Court* (1973) 9 Cal 3d 330. A patient is not obligated to sacrifice all privacy to seek redress for an emotional condition. The scope of the inquiry allowed depends on the nature of the injuries that the patient-litigant brings before the court. *Britt v. Superior Court* (1978) 20 C 3d 844.

The extent to which a mental component may be an issue in a case depends on the facts, and the burden is on the party seeking privileged information to establish its direct relevance. *Davis v. Superior Court* (1992) 7 CA 4th 1008. The filing of a workers' compensation claim is a qualified waiver of the physician-patient privilege but not of the Constitutional right of privacy. *Allison v. WCAB* (1999) 64 CCC 624.

Based on these legal principles, the panel concluded that the determination of the allowable extent of discovery requires a balancing of the applicant's right to privacy against allowing relevant and necessary discovery. In the opinion of the Board, because the applicant controls what is claimed in the litigation, the analysis begins

with the consideration of what disability is being claimed. Here, applicant made no claim of psychiatric injury. Thus, defendant was limited to inquiring about psychiatric or psychological treatment received for the stipulated injuries. The defendant was not entitled to ask about her entire past psychiatric history.

Although the doctor reported a functional overlay and referred applicant for psychiatric evaluation, there was no indication the applicant was depressed or taking any antidepressant medication when she was evaluated in 2000. The doctors did not attribute any permanent disability to psychiatric factors. The opinion of the doctor was outdated and no longer pertinent. Although the applicant received psychological counseling and medication as part of the pain management program, all pain management programs will likely include some psychological component.

Because the applicant has strictly avoided making a claim for psychiatric injury, and the defendant had not made a clear showing that any psychiatric condition was relevant to the pending issues of PD and medical treatment, the majority was not persuaded that either the outdated defense evaluation or applicant's participation in the pain management program justified compelling applicant to disclose her entire psychiatric history. To allow the defendant to use its own medical evaluation and applicant's participation in pain management to force her to choose between abandoning her physical injury and revealing distressing private information would violate the fundamental underpinnings of the ***Allison*** decision.

As to the remedy, the majority took the position that reconsideration after trial would not have been an adequate remedy. The threat of loss of applicant's privacy rights would have caused substantial prejudice and irreparable harm, and that could not be cured on reconsideration. Therefore the Board found sufficient grounds for removal under WCAB Rule §10843. The majority removed the case to itself, rescinded the WCJ's discovery order, and returned the case to the WCJ with instructions that defendant could ask applicant about any medication that might interfere with her deposition, any antidepressive medication she was currently taking, any psychological or psychiatric treatment provided as part of the pain management program, and any medication provided in the pain management program.

If applicant was currently taking antidepressant medication, defendant could ask who prescribed it and whether it was for the industrial injury. If it was not prescribed for the industrial injury, defendant could not inquire further in the absence of medical evidence demonstrating that a current nonindustrial psychiatric condition was somehow related to the injury.

The dissenting opinion indicated that the defense report tended to establish that psychological factors were contributing to applicant's disability. The commissioner then distinguished ***Britt*** and ***Davis*** and stated there was evidence in this case that applicant's psychiatric condition might be relevant to the medical

condition placed in issue. Thus, in the opinion of the dissent, there was a reasonable and nonspeculative basis for questioning whether some or all of applicant's physical complaints had a psychogenic component. When an injured worker places pain in issue, inquiry cannot be limited on the cause of the pain. If there is nonspeculative evidence that the psychiatric condition is contributing to the pain for which benefits are claimed, the defendant is entitled to inquire in the psychiatric area. The commissioner would have denied removal.

3. *Mendoza v. Republic Indemnity Co.* (2001) 29 CWCR 228 (Board Panel Decision).

The applicant injured his back on May 4, 2000. The defendant accepted liability and arranged for treatment with a Dr. Sajedi. Less than a week after the injury, the doctor wrote a brief report to the effect that the applicant was being released from care for regular duty work. The doctor submitted no further reports until September 26 when he confirmed the applicant's disability was permanent and stationary and that no further treatment was indicated. In the interim, the applicant had retained an attorney and was referred to a Dr. Hunt for treatment.

At a mandatory settlement conference, a workers' compensation judge ruled Dr. Hunt's report was not admissible because applicant had not objected to Dr. Sajedi's release from treatment in the manner prescribed by L.C. §§4061 and 4062 and AD Rule §9785(b). The matter was then set for a formal hearing before another WCJ.

The new WCJ tentatively indicated he would receive Dr. Hunt's report in evidence. The new WCJ indicated that the defendant was estopped from relying on L.C. §§4061 and 4062 because it had failed to advise applicant, who was unrepresented at the time, of his right to an evaluation by one of three QMEs nominated by the Industrial Medical Council. The WCJ indicated that the report of Dr. Sajedi was not substantial evidence and ordered the matter off calendar for permanent and stationary reports.

Defendant filed a petition for reconsideration or, in the alternative, removal. The Board granted reconsideration for study, and after study the panel concluded that the second WCJ was correct. The Board indicated that L.C. §4600 gives injured workers the right of free choice of physician after 30 days, but if the primary treating physician determines there is no need for continuing treatment and there is no dispute concerning its need, no other primary treating physician can be selected until the dispute is resolved. (AD Rule §9785(b)). The injured worker, however, must have knowledge that the primary treating physician intended to discharge him before he can be required to pursue the remedies under L.C. §§4061 and 4062. Operation of L.C. §4061 is dependent on notice and information being provided with the last payment of temporary disability.

Similarly, L.C. §4062 begins with the statement that if either the employer or employee objects to a medical determination made by the primary treating

physician concerning, among other things, the extent and scope of medical treatment, the objecting party must follow certain procedures. In this case the panel concluded there was no last payment of compensation, but AD Rule §9812 (f)(4) mandates that when a claims administrator takes the position that an injury has caused no PD, the administrator must inform the employee that no PD is payable and describe the steps necessary to obtain a QME evaluation and other remedies.

AD Rule §9812(g)(3), moreover, requires that the notice include specific language about the availability of help from an information and assistance officer and the right to consult an attorney. Relying on AD Rule 9812 and the statute, the panel stated that the injured worker is entitled to the notice as required by AD Rules before L. C. §§ 4061 and 4062 limitations on medical reports come into play. The rationale for this is analogous to the well-established rule that an employer that fails to give an injured worker the benefit information required by AD Rules is estopped to assert the statute of limitations. See *Galloway v. WCAB* (1998) 63 CCC 532.

The injured worker must also know that the primary treating physician is discharging him before he is obligated to object and await resolution of the need for treatment issue before exercising his right to be treated by a physician of his own choice. There was no showing that a copy of Dr. Sajedi's initial report had been served on applicant or that the applicant was aware of it before he sought treatment from Dr. Hunt. Under these circumstances applicant was entitled to exercise his free choice.

The panel did agree with the defendant that when a worker is denied medical treatment and retains an attorney, the attorney would be well advised to object to the treating physician's report, presuming that the attorney had notice of it. Here, however, it did not appear the applicant had been discharged by Dr. Sajedi, and even if he had been, he was not informed, and Republic Indemnity Co. failed to give the information mandated by the AD rules about his rights and remedies. Under these circumstances, applicant was not precluded from substituting Dr. Hunt as the primary treating doctor. Accordingly, as its decision after removal, the panel affirmed the WCJ's April 12, 2001 rulings.

4. *Rivas v. Zurich American Insurance Company* (2001) 29 CWCR 253 (Board Panel Decision).

Applicant was injured on December 6, 2000. Defendants accepted liability and provided medical treatment. On January 11, 2001, the treating physician released applicant from care and wrote that her disability was permanent and stationary and she could return to work without restrictions. Applicant's attorney objected to the treating physician's report and on March 6 suggested the names of three acceptable agreed medical evaluators. His letter stated in part, "If we do not hear from you

within the next ten days, we will schedule an appointment with a qualified medical evaluator."

That same day, however, the attorney made an appointment for applicant to be seen by Ronald Perelman, M.D. as a QME. The exam was set for March 23.

No agreement on an AME was reached with the defendants. Applicant's attorney declared that he had a lengthy AME/QME discussion with the defendant's claims manager during the ten-day period provided in L.C. §4062 for agreement of an AME.

Dr. Perelman examined the applicant and prepared a comprehensive medical evaluation. On July 12, at a formal hearing before a workers' compensation judge, defendant objected to Dr. Perelman's report, and the WCJ ruled that applicant's attorney did not trigger the provisions of the AME/QME dance because the selection of the QME was made on the same day the AME letter was sent. The judge issued an order excluding the report.

Applicant petitioned for reconsideration. The board panel concluded that the WCJ had erred. The panel quoted L.C. §4062 to the effect that when an injured worker is represented by an attorney, the parties must seek an agreement on an AME. If no agreement is reached within 10 days or within an additional time agreed to by the parties, not to exceed 20 days, parties may not later select an AME. Evaluations obtained before the period to reach agreement are not admissible in any proceedings before the WCAB. After the period has expired, the objecting party may select a QME to conduct the comprehensive medical evaluation. With the exception of reports prepared by the treating physicians, no report determining the disputed medical issues may be obtained before the expiration of the period to reach agreement on an AME. Reports obtained in violation of that prohibition are not admissible.

The panel then concluded that they construe the phrase "may select a qualified medical evaluator to conduct the comprehensive medical evaluation" to mean that the employee may not attend an examination before that date. To construe it otherwise would be to intrude into the areas of attorney-client privilege and attorney-client management strategy. This would require an impermissible scope of inquiry. Questions about whether an attorney and client can discuss the selection of a QME during the 10 days and when an attorney can make the appointment are irrelevant to the Reform Act purpose of limiting the number and costs of medical evaluations.

The intent of the Reform Acts, the panel explained, is to provide a faster and more expeditious remedy for injured workers than heretofore. Making a tentative reservation of time with a potential QME may be a practical way for the attorney to speed up the resolution of the client's case. The policy behind L.C. §§4060 to 4068 is to limit the expense of litigation, not delay it. The scheduling of a QME

examination while attempting to agree on an AME is not, therefore, a violation of L.C. §4062. The QME evaluation may not be excluded from evidence on the sole ground that the appointment was made during the period for agreement.

Accordingly, the panel granted reconsideration of the judge's order excluding the medical report on the sole basis that the appointment for the examination was made during the period for agreement on an AME.

5. *San Diego Trolley, Inc. v. The Superior Court of San Diego County* (2001) 66 CCC 352.

Danielle Kinder was severely injured in August 1998 when she attempted to climb over a coupling device of two trolleys operated by petitioner, San Diego Trolley. She was on the eastbound platform when she discovered she wanted to get the westbound trolley. She was able to step over the east bound coupling, but when she attempted to step over the westbound coupling, the trolley started up without warning, and she was severely injured when she was trapped beneath. Kinder sued the trolley company claiming negligence because the trolley driver, Sheryl Cooper, failed to activate a buzzer and make a public announcement warning that the trolley was about to depart.

At Cooper's deposition it was learned that Cooper had been suffering anxiety attacks since the murder of a trolley passenger in 1995. She was treated by a psychiatrist and was taking medications. She had informed her supervisors of her treatment and her medication. Following the incident with Kinder, Cooper was unable to return to work as a trolley driver, and she filed a stress-related workers' compensation claim.

Kinder served San Diego Trolley with a notice to produce Cooper's personnel file. Kinder served subpoenas on Cooper's HMO, the workers' compensation insurance carrier and the attorneys who participated in Cooper's worker's compensation claim. Cooper objected on the basis of privacy. Kinder moved to compel responses to her discovery requests, arguing that Cooper waived her psychotherapist-patient privilege by revealing her condition at the deposition and by filing a workers' compensation claim. Kinder claimed her need to prosecute her third party claim outweighed Cooper's right to privacy. The trial court granted Kinder's motion to compel. Both Cooper and San Diego Trolley filed a petition for writ of mandate seeking to vacate the order of the trial court.

The court held that Cooper's psychotherapist-patient privilege is set forth in Evidence Code §101, and her right of privacy is guaranteed by Article 1, Section 1 of the California Constitution. The court noted that the state Supreme Court has consistently recognized the public interest in supporting effective treatment of mental illness and consequent public importance of safeguarding the confidential character of psychotherapeutic communication. Such therapy depends on the fullest revelation of the most intimate and embarrassing details of a patient's life

and that a patient must be assured that such information will be kept in the utmost confidence, otherwise the patient may be reluctant to make the full disclosure upon which successful diagnosis and treatment depend. The privilege may survive even broad disclosure of a communication because the psychotherapeutic relationship may survive such a disclosure. This privilege is not subject to a good cause exception in personal injury actions, but the physician – patient privilege is where a patient is dangerous and disclosure may prevent harm to himself or a third person.

The psychotherapist-patient privilege may be waived when the patient voluntarily discloses otherwise confidential information or tenders her mental state as an issue. Such waiver must be a knowing act done with sufficient awareness of the relevant circumstances and likely consequences. When a patient does disclose confidential information or put her mental state in issue, she does not lose all privacy interest in information otherwise protected by the privilege. Any waiver must be narrowly construed and limited to matters that it can reasonably said the patient no longer retains a privacy interest. The court says there is a vast difference between disclosure of a general description of the object of the psyche treatment and the disclosure of all or part of the patient's actual communications during therapy. Any waiver of the privilege must be construed not as a complete waiver, but only a limited waiver consistent with the purposes of the exception.

Any waiver of the privilege which has occurred in one proceeding must be carefully limited with respect to its later use in an entirely unrelated proceeding. Fundamental to the right of privacy is the ability to control its circulation.

The court concluded that Cooper is entitled to prevent disclosure of any confidential communications she had with her psychiatrist. Cooper made only a limited disclosure for the purpose of treating in her workers' compensation case. At her deposition in the third party case, she only disclosed that she was treating with a psychiatrist and what medications she was prescribed. Her testimony did not disclose any of her communications with her psychiatrist. Cooper never yet testified in her workers' compensation case, and, in fact, she was still treating; therefore none of her confidential communications were yet disclosed in her workers' compensation case. The court held that Kinder has not met the burden of demonstrating not only that the information is material to disposition of the litigant's rights, but also that there is no other less intrusive means of obtaining the needed information. The court said Kinder could demonstrate the existence of Cooper's impairment by way of expert testimony.

Next, the court held that Kinder is entitled to know of any warning Cooper's psychiatrist may have made to San Diego Trolley prior to Kinder's injury that Cooper was a danger to herself or to others per Evidence Code §1024.

As to the personnel records and employment information, the records will remain protected from disclosure. The court must balance the public interest in preserving

confidential information with the interest of the private litigant in obtaining the information. The litigant must show a compelling need for the particular documents and that the information sought cannot reasonably be obtained through deposition or non-confidential sources. Here Kinder has not shown a compelling need for Cooper's records. The court held the only information San Diego Trolley must disclose is whether it received any warning from Cooper's psychiatrist that Cooper was a danger to herself or others.

The writ of mandate was granted, and the discovery order of the trial court was vacated.

6. *State Compensation Insurance Fund V. The Superior Court of Los Angeles County* (2001) 66 CCC 1061.

On March 19, 2001, the Los Angeles County District Attorney sought and obtained a search warrant authorizing a search of the offices of State Compensation Insurance Fund for "all documents pertaining to the Workers Compensation claim filed by Larry Nign against his employer, Race- Craft." The application for the search warrant was supported by a sealed affidavit. The Superior Court issued the search warrant specifically authorizing a search for reports, memoranda, notes, letters, and correspondence generated to and from the State Fund legal files regarding Larry Nign's claim as well as a search of the offices occupied by State Fund's in-house lawyers.

On March 22, 2001, the search warrant was executed and a special master accompanied the executing officers to monitor the search as required by the Penal Code. Five boxes of documents were seized and were sealed by the special master at the request of State Fund. State Fund then filed a notice of motion for an in camera hearing to review the sealed files to identify documents that were covered by the attorney-client privilege or work product doctrine to prevent their disclosure.

On March 29, 2001, the trial court heard State Fund's motion. The District Attorney opposed the motion on the ground that the crime/fraud exception overrides any attorney-client privilege and that State Fund does not have standing to assert any privilege. The District Attorney argued that their sealed affidavit was sufficient to prove the crime/fraud exception and furthermore, the District Attorney had obtained a waiver of the attorney-client privilege signed by the owner of Race-Craft which the District Attorney offered as evidence that State Fund lacked evidence to assert the attorney-client privilege. The trial court denied State Fund's motion and ordered that the seized documents be unsealed. State Fund filed a motion for reconsideration, contending that established law requires the trial court to conduct an in camera inspection of the seized documents to determine if any of them are privileged and, therefore, should remain sealed until such inspection takes place. State Fund argued that the District Attorney must make a prima facie showing of the crime/fraud exception in order to overcome the

attorney-client privilege. Reconsideration was denied and State Fund filed a Petition for writ of mandate.

As to the issue of standing the Appeals Court found no merit to the contention of the District Attorney that the insured employer, Race-Craft, could waive State Fund's attorney-client privilege. The client is the holder of the attorney-client privilege.

A client is a person who consults a lawyer for the purpose of obtaining his professional advice. Person includes corporation and other associations such as State Fund. State Fund may retain lawyers to perform legal services and render advice to it without bestowing "holder" status on the insured. This is well established in the provisions of L.C. § 3762. Race-Craft may not waive State Fund's attorney-client privilege.

The District Attorney contends that the Penal Code requires that the party claiming a privilege must request the sealing of specific items at the time the documents are seized in order to preserve the privilege. The court disagrees. There is no legal mandate that the party must claim a privilege item by item as the documents are seized. Furthermore, State Fund had no idea what had been seized. Therefore, State Fund is not precluded from claiming privilege and from requesting an in camera hearing. The court says that while an in camera proceedings may be burdensome and time-consuming there is no short cut to the required procedure. To rule otherwise may encourage wholesale seizure of voluminous documents rather than sharply focused searches.

The trial courts ruling, that the sealed affidavit supporting the application for the search warrant was sufficient to invoke the crime/fraud exception to the attorney-client privilege, was error on its face.

The affidavit was sealed and State Fund was not privy to its contents. Second, the affidavit must be sufficient to establish a prima facie case of fraud if a party is seeking to apply the crime/fraud exception. The party must establish a reasonable relationship between the fraud and the attorney-client communication. Here no prima facie showing has been made.

The court also finds that State Fund is entitled to the attorney work product privilege under the Code of Civil Procedure. It can only be asserted by the attorney. Here the State Fund did not waive the privilege. Furthermore, the crime/fraud exception does not apply to the attorney work product privilege.

The Appeals Court issued the requested writ of mandate commanding the trial court to conduct an in camera hearing for a determination as to what documents were protected by privilege.

7. *Stewart v. Colonial Western Agency, Inc*. (2001) 87 Cal.App. 4th 1006, 105 Cal.Rptr. 115.

In an opinion certified for publication, the Court of Appeal affirmed the trial court's imposition of $2,400.00 in discovery sanctions against defense counsel for improperly instructing a witness not to answer questions during a deposition. The deposition was taken in the context of a wrongful termination/breach of contract action. Defense counsel instructed the witness, an employee and managing agent of defendant, not to answer numerous questions on the sole basis the questions asked were not calculated to lead to the discovery of admissible evidence. In response, plaintiff's counsel indicated his intention to move to compel further answers and to seek appropriate sanctions. Post-deposition, there was an attempt made by plaintiff's counsel to informally resolve the discovery dispute. The trial court indicated the only ground or basis for instructing a deponent not to answer a question is a legitimate and timely claim or assertion of privilege.

Unless otherwise limited by order of the court in accordance with the discovery statutes, any party may obtain discovery regarding any matter not privileged, that is relevant to the subject matter involved in the pending action ...if the matter either is itself admissible in evidence or appears reasonably calculated to lead to the discovery of admissible evidence. Discovery may relate to the claim or defense of the party seeking discovery or of any other party to the action. For discovery purposes, information is relevant if it might reasonably assist a party in evaluating the case, preparing for trial, or facilitating settlement. Admissibility is not the test and information unless privileged, is discoverable if it might reasonably lead to admissible evidence. The rules are applied liberally in favor of discovery, and (contrary to popular belief), fishing expeditions are permissible in some cases.

The Court further articulated a test dividing objectionable deposition questions into 3 categories. The categories are: 1) privilege, 2) errors in the form of the question, and 3) irrelevant and immaterial matters. Only category 1, a claim of privilege can form the basis of an instruction to a witness not to answer a question.

Moreover, even were the questions designed to elicit irrelevant evidence, irrelevance alone is an insufficient ground to justify preventing a witness from answering a question posed at a deposition. Code of Civil Procedure §2025(m), governing deposition objections, divides objectionable questions into three categories. Subdivision (m)(1) applies to questions delving into privileged areas and provides that, to protect privileged information, "a specific objection to its disclosure" must be "timely made during the deposition." Subdivision (m)(1) thus sanctions use of an objection coupled with an instruction not to answer in order to protect privileged information from disclosure. Subdivision (m)(2) applies to questions containing errors or irregularities that might be cured if promptly brought to counsel's attention, such as errors in the form of the question. Objection to these types of missteps are "waived unless a specific objection to them is timely made during the deposition." Subdivision (m)(2) makes clear that counsel should

not instruct the deponent not to answer such objectionable questions, expressly stating that "unless the objecting party demands the taking of the deposition be suspended to permit a motion for a protective order under subdivision (n), the deposition shall proceed subject to the objection." Subdivision (m)(3) governs inquiry into irrelevant and immaterial matters and provides: "Objections to the competency of the deponent, or to the relevancy, materiality, or admissibility at trial of the testimony or of the material produced are unnecessary and are not waived by failure to make them before or during the deposition. In other words, deponent's counsel should not even raise an objection to a question counsel believes will elicit irrelevant testimony at the deposition. Relevance objections should be held in abeyance until an attempt is made to use the testimony at trial.

In some special circumstances, a deposition may be suspended "...by either party for the purpose of obtaining a protective order on the grounds that the "...examination is being conducted in bad faith or in a manner that unreasonably annoys, embarrasses, or oppresses that deponent or party."(CCP §2025(n)). However, the court cautioned that suspension of a deposition is only warranted where there is an interrogation which "reveals an underlying purpose to harass, annoy, etc." "[W]itnesses are expected to endure an occasional irrelevant question without disrupting the deposition process. The Court strongly intimated that a party who improperly suspends a deposition might be subject to sanctions in the form of costs related to reopening "...an improperly suspended deposition and for improperly seeking a protective order."

XII Liens and Lien Claimants

1. *Blue Cross of California v. WCAB (Blofsky)* (2001) 66 CCC 1073 (writ denied).

Applicant claimed three industrial injuries which were eventually resolved by Compromise and Release for $30,000. In the Compromise and Release, defendants proposed reducing lien claimant's medical treatment lien using the formula set out in *Kaiser Foundation Hospital v. WCAB* (*Gregory*) (1978) 43 CCC 1300. In the C&R applicant and defendant also indicated there was a good faith issue of injury AOE/COE and asked the WCJ to make a *Thomas* finding.

Applicant's medical-legal evaluator gave an opinion that applicant's injuries were AOE/COE. Defendant's medical-legal evaluator believed applicant had not sustained an industrial injury.

Lien claimant provided medical treatment for applicant's injuries as part of a group health insurance policy and then filed the lien for the medical treatment.

Lien claimant objected to the use of the Gregory formula. The WCJ held a hearing on the Gregory formula and lien claimant's objection. The WCJ ordered the parties to submit briefs on the injury AOE/COE issue. After submission of the briefs, the

WCJ approved the C&Rs proposed by the applicant and defendant with a Thomas finding. Using the Gregory formula, the WCJ evaluated applicant's case at $135,624. The WCJ then reduced the medical treatment lien to $15,992.46, approximately 22.1 percent of the lien amounts.

Lien claimant sought reconsideration of the order approving C&R. In its objection to the Gregory formula, lien claimant contended that reduction of the lien under the Gregory formula was unconstitutional because it was based on a valuation of applicant's case equal to applicant's maximum potential recovery from her injuries based on the applicant's report, as if she prevailed on all issues, when the WCJ, instead, should have used the reasonable potential case value of applicant's claims.

Lien claimant also contended the *Gregory* formula, as used here, did not adequately specify the parts of the record supporting the WCJ's computation of the applicant's potential recovery. Finally, lien claimant contended the WCJ did not properly follow the formula set out by the Court in *Gregory*.

In his report and recommendation on reconsideration, the WCJ stated that this was a case with a bona fide *Thomas* finding. There was substantial evidence to support the denial of applicant's contentions in total. The reports of the defense reporting doctor clearly support a take-nothing for the applicant in this case. On the other hand, the applicant's report shows a compensable injury and sizable permanent disability. In the judge's opinion, this is, in effect, an all-or-nothing case which faced the applicant. A reasonable settlement offer was procured and the formula properly applied.

The WCJ went on to write that he never understood the law to be that each and every element of the *Gregory* formula must be proved up. The idea of Compromise and Release is to avoid the perils and hazards and expenses and the uncertainty of trial, and to that end the *Gregory* formula facilitates same.

In this case the WCJ indicated the ratio the lien claimant received is the ratio that applicant received and it would be an all-or-nothing case otherwise, which might be very unfair to one party or the other. The parties reasonably calculated the chances of prevailing and arrived at a figure which the judge could approve. $30,000 is clearly within the range of evidence as presented upon review of the medical records considering the liability. The judge recommended reconsideration be denied.

The WCAB adopted and incorporated the WCJ's report, denying reconsideration without comment.

Lien claimant filed a petition for writ of review, which was denied.

2. *Golden Gate Bridge District v. WCAB (Alvarado)* (2001) 66 CCC 1362 (writ denied).

At an MSC on August 10, 2000, the parties resolved the applicant's case- in-chief related to her claims for specific and CT injuries to her spine by way of Compromise and Release for $2,500, which included a Thomas finding. The judge issued an order approving the Compromise and Release.

Applicant received medical treatment from Rodney Sweet, D.C. Dr. Sweet filed a lien for his treatment totaling $6,640, which was left to be adjusted or litigated by the terms of the Compromise and Release. The lien claim issue was set for trial on October 20, 2000. The hearing became an MSC, and the matter was set for trial again on December 19, 2000.

Applicant and Dr. Sweet testified at the trial, and the doctor presented an amended lien of $11,672. After the trial the judge issued a Finding and Order whereby the judge found two injuries AOE/COE to applicant's spine, a specific injury and a continuous trauma. The WCJ also found Dr. Sweet's treatments were reasonably required to cure or relieve from the effects of the injuries and ordered defendants to adjust the lien and reimburse the doctor under L.C. §4600, with the WCAB retaining jurisdiction over the dispute.

The defendants sought reconsideration on the grounds that, one, they disputed representation of both applicant and Dr. Sweet by the same law firm, contending this was a conflict of interest; two, they contend the lien should have been denied because it did not comply with reporting requirements; and, three, they contended the WCJ denied defendants due process rights by denying defendants request to produce evidence rebutting Dr. Sweet's lien.

The WCJ's report addressed defendant's contentions. On the dual representation argument and conflict of interest, the WCJ indicated that it did not appear the representation by the same law firm was adverse to the interests of the applicant. In fact, the WCJ ruled, it appeared that in representing the doctor, the law office was actually acting in a manner consistent with the interests of the injured worker.

As to defendant's second contention, that the doctor completely failed to comply with reporting requirements under AD Rule §9785, the WCJ noted that defendant's denial of injury and denial of treatment relieved the doctor's obligation to comply with the AD Rule §9785.

Lastly, the WCJ discussed the due process contention. At the hearing the defendant's motion for a supplemental report from Dr. Swanson and/or to present expert medical testimony at the trial was denied on the grounds that defendants had not shown why it was, with reasonable diligence, the evidence disclosed by the lien claimant, Dr. Sweet, could not have been obtained prior to the hearing of August 10, 2000 or the hearing of October 20, 2000. The WCJ wrote that if a party has been given notice of a claim being asserted against it and fails to take the

opportunity to conduct discovery or otherwise investigate the claim, there can be no denial of due process.

The WCAB denied reconsideration, adopting and incorporating the WCJ's report on issues of dual representation and lien claimant's reporting requirements. The WCAB also discussed defendant's due process contentions. The Board indicated that at the mandatory settlement conference of August 10, 2000, the parties executed a Compromise and Release agreement that included defendant's agreement to adjust or litigate Dr. Sweet's lien claim. An addendum to the Compromise and Release agreement refers to Dr. Sweet's report not supporting the claim of injury, apparently written in the handwriting of the defense attorney.

The order approving Compromise and Release clearly designates defendants to serve the order approving Compromise and Release on Dr. Sweet, and the WCJ further stated that the liens will be set for trial within 30 days unless the WCAB is advised that the liens have been resolved. The record clearly establishes that defendants were aware of the existence of the reports prepared by Dr. Sweet as early as the August 10, 2000 MSC, if not before then.

The addendums give rise to further inference that defendants were aware of the contents of the reports. At the October 20, 2000 hearing, notwithstanding defendant's desire to immediately proceed to trial, the WCJ converted the hearing to an MSC to allow the parties to disclose the evidence they have and also disclose witnesses and be able to present whatever witnesses they need at the hearing. The pretrial conference statement prepared on October 20, 2000 does not reflect the defendants either listed rebuttal witnesses or raised any further objections to closing discovery at the conclusion of the MSC.

The record indicates that defendants had the opportunity to request the reports if they had not seen them and the opportunity to seek rebuttal at least two months before they urged that the matter proceed to trial immediately on October 20, 2000. Defendants had the opportunity to cross-examine Dr. Sweet at the hearing of December 19, 2000. The minutes of that hearing reflect defendants did not avail themselves of that opportunity to cross-examine the doctor.

Under these circumstances, the Board indicated they saw no substantial evidence that would support defendant's claim they have been denied due process of law in the proceedings.

The writ was denied. In the denial of the writ, the Court wrote as follows: Dr. Sweet was not bound by the applicant's Thomas stipulation and could not have been expected to shoulder the burden of proof on industrial causation until he learned of applicant's settlement. California Code of Regulations Title 8 §10770(e) prevented Dr. Sweet from formally amending his lien claim earlier. The Board did not abuse its discretion in concluding petitioner should have been fully prepared to try the lien claim before the settlement conference. Petitioner has no standing to

object to the representation of both the applicant and the doctor by the same law firm. The writ was denied.

XIII Vocational Rehabilitation

1 *Niedle v. WCAB* (2001) 66 CCC 223.

The question presented here is whether L.C. §4644(g) violates the equal protection clause of the U.S. Constitution where it requires an out-of-state vocational rehabilitation plan to be more cost-effective than an in-state plan. Here the Court held that the code section does not impede the right to travel, nor does it violate the equal protection clause where the code section does serve a rational purpose.

The petitioner sustained an industrial injury and suffered sufficient permanent disability such that she required vocational rehabilitation. Thereafter the petitioner moved to Nevada. The parties agreed on a rehabilitation plan for the petitioner to complete courses necessary to qualify her for a teaching credential. The rehabilitation coordinator compared the cost of obtaining the credentials in Nevada as opposed to California. The cost in Nevada was greater by $637.00. Based upon Labor Code §4644(g) the defendant refused to pay for the plan. The Rehabilitation Unit decided in favor of the defendant. The petitioner appealed, contending the statute violated her constitutional right to travel. The WCJ upheld the decision of the Rehabilitation Unit, also stating that he had no jurisdiction to determine the constitutionality of a statute. The Board granted reconsideration, then affirmed the WCJ's decision. The petitioner filed for writ of review which was denied. The Supreme Court then granted the petition for review and transferred the matter back to the DCA with directions to issue a writ of review. After reconsidering the matter, the DCA concluded that L.C. §4644(g) is not unconstitutional.

The DCA first states that the Board lacks the authority to declare a statute unconstitutional, so the standard of review is de novo.

With respect to the right to travel the Court held that the petitioner was not penalized. She could not support the proposition that a classification based upon residence is subject to strict scrutiny when attacked by one who has migrated from the state which denied the benefit in question. The petitioner produced no cases on point to support her proposition. As to the equal protection argument the Court said before determining whether a statute operates to deny an equal protection of the law, the appropriate standard of review must first be determined. When reviewing the legislative classifications under the equal protection clauses of both the constitution of the United States, as well as that of California, the classification is generally presumed to be constitutional. However, once it is determined that a classification scheme affects a fundamental right or interest, the burden shifts. Thereafter, the state must first establish that it has a compelling

interest which justifies the law and then demonstrate that the distinctions drawn by law are necessary to further that purpose.

If a fundamental interest or a "suspect classification" is not at stake, the inquiry is less stringent because the reviewing Court is merely directed to the question of whether or not the statutory classification bears a rational relationship to a conceivable legitimate state purpose.

The cases cited by the petitioner dealing with the right to travel all involved the obligation and responsibility of the claimant's new state of residence, but here the petitioner seeks to enforce an obligation against the state of former residence. That distinction is critical. The Court says any primary obligation to ascertain a citizen's economic status or condition and to make provision for their well-being falls upon the state of current residence, not on the state of former residence. It is a fact of our federal system that a state has responsibility to exercise its welfare powers for current residents. Here the petitioner is only subjected to a different requirement in order to receive a California benefit in another state. The right to travel is not violated by such different requirement.

The Court states that a law is not in violation of the equal protection clause if it advances legitimate government interest. This is true even if the law seems unwise or works to the disadvantage of a particular group, or if the rationale seems tenuous. A statutory classification must be upheld against an equal protection challenge if there is any statement of reasonably conceivable facts that could provide a rational basis for the classification, as long as the classification does not proceed along suspect lines or infringe upon a fundamental constitutional right.

Here, the purpose of the Workers' Compensation Reform Act of 1989 and subsequent clean up legislation of 1992 [which included L. C. §4644(g)] was to cut the cost of workers' compensation so that business would not flee from the state.

There are higher costs involved in monitoring out-of-state vocational rehabilitation plans. To help reduce costs, California enacted L.C. §4644(g) which prohibited any out-of-state plan which cost more than the same plan within the state. The Court found that this is a rational basis for the distinction between in-state and out-of-state vocational rehabilitation plans.

The Board's order denying reconsideration was affirmed.

2. *Petropoulos v. Superior National Insurance Company* (2001) 29 CWCR 158 (Board Panel Decision).

Applicant claimed a cumulative injury to his gastrointestinal system as a result of stress from his employment. Defendant denied liability. Applicant's attorney demanded that defendant provide rehabilitation services on February 17, 1999. The matter proceeded to trial, and, in a Findings and Award dated April 10, 2000,

the WCJ found the applicant sustained an injury and was temporarily disabled until February 28, 1999 and was permanently precluded from exposure to unduly stressful work. After a rehabilitation conference the consultant determined that applicant was a qualified injured worker entitled to vocational rehabilitation services, and entitled to vocational rehabilitation maintenance allowance at the temporary disability rate commencing the day after temporary disability benefits terminated. The rehabilitation consultant stated that in view of the fact that the defendant had not provided any vocational rehabilitation benefits, it clearly delayed provision of vocational rehabilitation. Pursuant to Labor Code § 4642 and A.D. Rule §10125.1, vocational rehabilitation maintenance allowance, payable from March 1, 1999 until defendant starts paying it, will be payable at the temporary disability rate and will not apply to the cap.

Defendant filed an appeal to the decision contending that the Rehabilitation Unit erred in relying on applicant's medical evidence, that applicant was not eligible for vocational rehabilitation on March 1, 1999, and that vocational rehabilitation maintenance allowance should not be payable at the temporary disability rate because provision of vocational rehabilitation was not delayed.

The matter was submitted to the WCJ. The WCJ issued a decision affirming the Rehabilitation Unit's finding that applicant was a QIW, but modifying the vocational rehabilitation maintenance allowance determination to make it payable at the vocational rehabilitation maintenance allowance rate until May 12, 2000 and thereafter at the temporary disability rate. The WCJ found applicant's medical evidence credible and substantial, but concluded that because defendant was contesting injury, its liability to provide benefits was not clearly established until the April 10, 2000 Findings and Award. Medical substantiation of applicant's QIW status first appeared in a May 12, 2000 medical report. Thus, vocational rehabilitation maintenance allowance at the temporary disability rate started on that date.

Applicant and defendant both sought reconsideration. Applicant contended that he was entitled to vocational rehabilitation maintenance allowance at the temporary disability rate from the last payment of medical temporary disability because defendant failed to comply with L.C. §4637 and delayed in providing vocational rehabilitation services. The delay was caused by defendant's denial of liability, and the delay was not related to the May 12, 2000, medical report because that medical report merely confirmed applicant's previously determined inability to return to his usual stressful occupation.

The Board granted reconsideration for study and then issued a decision rejecting defendant's arguments for the reasons set forth by the WCJ.

Turning to the applicant's petition, the panel disagreed with the WCJ's reasoning on the rate at which vocational rehabilitation maintenance allowance should be paid

from the end of medical temporary disability until May 12, 2000. L.C. §4642 applies regardless of the reason for the delay.

L.C. §4642 provides that if an employer fails to assign a qualified rehabilitation representative or to commence vocational rehabilitation services in a timely manner or otherwise causes any delay in the provision of vocational rehabilitation services, the full maintenance allowance shall be paid for the period of the delay. The maintenance allowance and any costs attributed to the delay are not subject to the overall cap on the expenses.

The panel went on to state that L.C. §4642 is not limited to delays for which the defendant had no reasonable basis. Regardless of whether defendant had a reasonable basis for delaying vocational rehabilitation, services while it contested liability, it did delay vocational rehabilitation and the full maintenance allowance was payable for the period of delay. The portion of the maintenance allowance and any costs attributed to the delay, moreover, is not subject to the cap.

The Board affirmed the Rehabilitation Unit's Determination rescinded the WCJ's decision and substituted a finding that applicant was entitled to vocational rehabilitation maintenance allowance at the temporary disability rate beginning March 1, 1999 and continuing during the period benefits were delayed and that these benefits were not subject to the cap.

3 *Pinzon v. Liberty Mutual Ins. Co.* (2001) 29 CWCR 127 (Board Panel Decision).

Applicant was injured in the course of her employment. The employer did not make a formal offer of modified or alternative work, but the applicant returned to work and continued to perform modified work. The applicant stopped modified work when her physical complaints forced her to stop working. The applicant was injured on September 15, 1997, and stopped the modified work on September 1, 1999. On February 15, 2000, the parties stipulated that vocational rehabilitation was unnecessary because the applicant was working. Subsequently, however, applicant requested vocational rehabilitation services and the Rehabilitation Unit held a formal conference. At the formal conference on September 27, 2000, it was discovered that the applicant was an undocumented worker.

On October 17, 2000, the Rehabilitation Unit determined that applicant was entitled to vocational rehabilitation services as a result of the 1997 injury. Defendant appealed. After a hearing, the WCJ filed an order denying the appeal and ruling that applicant was entitled to vocational rehabilitation maintenance allowance commencing July 28, 2000. Defendant petitioned for reconsideration contending that applicant's undocumented status precluded further work for the employer and any right to vocational rehabilitation services, that the applicant's working for over 12 months at modified work constituted a waiver of the employer's obligation to make a formal offer of modified work, and that applicant

declined vocational rehabilitation when she stipulated to an award in February 2000.

The panel indicated that the case of *Del Taco v. WCAB(Gutierrez*) (2000) 65 CCC 342, did not support petitioner's argument that applicant's undocumented status precluded further work for the employee and right to vocational rehabilitation services. In that case the decision was that the employer's obligation to provide vocational rehabilitation services is discharged if the injured employee is unable to accept an offer of modified or alternative work solely because of his or her illegal immigration status.

In this case, however, the employer never made an offer of alternative or modified work as required by Labor Code § 4644(a)(5). That section provides that the employer's liability for vocational rehabilitation services terminated if the employer offers and the employee accepts or rejects, in the form and manner prescribed by the administrative director, modified work lasting 12 months.

The manner of making offers of modified work is prescribed by the Administrative Director in AD Rule §10126(b)(1) which provides that offers to provide alternative or modified employment with the employer shall be made on DWC form RU-94. The injured employee shall accept or reject a bona fide offer within 30 calendar days of receipt of the offer. In the event that the offer is not accepted or rejected within 30 days, the offer is deemed rejected, unless the period of time for reply is extended by the employer or by the terms and conditions of a collective bargaining agreement. The claims administrator shall submit a copy of the acceptance or rejection of the employment offer to the Rehabilitation Unit within 30 days of the acceptance or rejection. In this case, the defendant did not make an offer of bona fide work to applicant in this manner. In the absence of an offer pursuant to the requirements of Labor Code § 4644(a)(5) and AD Rule §10126(b)(1), defendant did meet its obligation and its liability was not terminated by applicant's working at the allegedly modified work for over 12 months.

The Board also rejected defendant's argument that applicant's working for over 12 months at modified work constituted a waiver of the obligation to make a formal offer of modified work. The defendant had cited the case of *Bautista v. WCAB* (1998) 63 CCC 1060 (writ denied), to support their argument of waiver. The Board concluded that the present case was distinguishable from the *Bautista* case. In *Bautista* the notice was sent, but late. In this case the panel concluded the notice was never sent.

As to the defendant's last argument, the Board summarily disposed of this by indicating that the applicant did not stipulate that she was not entitled to vocational rehabilitation services, but merely stated that VR was unnecessary at the time because she continued to work. The circumstances then changed.

The panel denied reconsideration.

Note: The Court of Appeals has granted writ of review.

XIV Permanent Disability

1. *Cabezas v. Kragen Auto Parts* (2001) 29 CWCR 184 (Board Panel Decision).

Applicant was employed by Kragen Auto Parts as a cashier and stock clerk. In March 1997, she developed pain in her arms and received medical treatment, including wrist splints. At the time, the employer's insurer was Traveler's Insurance Company, but before 1997, the employer had been primarily self-insured. Applicant continued working until August 1998 when her treating physician took her off work. Travelers Insurance settled the entire claim by compromise and release and filed a petition for contribution against Kragen, self-insured. The petition for contribution was referred to an arbitrator. The arbitrator issued a decision finding a single cummulative trauma injury, with an ending date of March 1, 1997, and ordered Traveler's reimbursed for 92.4 percent of the year, having gone one year back from March 1, 1997, under L.C. §5500.5.

The self-insured filed a petition for reconsideration from the arbitrator's award. A board panel concluded that L. C. §5412 defines the date of injury in a cumulative injury case as when the employee first suffers disability from the injury, and either knows or in the exercise of reasonable diligence should have known the disability was caused by his employment. The Board indicated that although the need for wrist splints and work modification might have been enough to establish the date of injury for L.C. §5412, it was not necessarily the date of last injurious exposure under L.C. §5500.5.

The panel indicated that if the applicant continues to work after the L.C. §5412 date of injury and the disability increases, there is a question of fact as to whether the increase is the result of an old injury or a new one. If the disability is solely caused by the old injury, the employer's insurer during the last year of harmful exposure shall be liable for that injury. The Board cited *Western Growers v. WCAB* (2001) 58 CCC 323. If, on the other hand, a second injury occurs after the L.C. §5412 date of injury when the applicant returns to work, then there are two separate periods of injurious exposure, according to the case of *Aetna Casualty v. WCAB (Coltharp)* (1973) 38 CCC 712. The question of whether there is one injury or two is a question of fact to be determined from the facts of the case, the medical history and expert medical opinion.

Applying the facts to this interpretation of the law, the Board concluded that there was no indication whether the arbitrator thought there was a new injury after March 1, 1997, or whether the arbitrator even considered that issue. The Board indicated if the applicant, after becoming disabled, returns to work, a question of fact arises as to whether this disability was caused by the old injury or a new

injury or a combination of both. The arbitrator, in the opinion of the Board, must resolve this issue before reaching a liability issue.

The Board cited another panel decision, *Henderson v. Federal Insurance Company* (1999) 27 CWCR 286, where the Board noted there was a possibility of two separate injuries and returned the case to the arbitrator to re-weigh the evidence, in light of the applicable law. The Board indicated that since the arbitrator did not consider the possibility of two continuous traumas in this case, the matter was being remanded to the arbitrator for further proceedings and a new decision.

2 *Collins v. Centre Insurance Co.* (2001) 29 CWCR 107 (Board Panel Decision).

Applicant sustained a cumulative injury through August 15, 1997, to his back and knees. In July 1999, applicant selected Dr. Carl Maguire to be his primary treating physician. Two months after commencing treatment, Dr. Maguire reported applicant's disability was permanent and stationary. After a dispute concerning the amount of the disability rating which would reflect Dr. Maguire's findings, applicant obtained a QME evaluation by Dr. Korsh. When further discussions did not lead to resolution, a hearing was requested. At MSC the parties obtained consultative ratings of the physicians' reports. They then prepared proposed ratings under Labor Code §4065, applicant proposing 29%, and defendant 5%. After hearing the WCJ obtained a formal rating of 7%. The WCJ then issued Findings and Award awarding 7% permanent partial disability. Applicant sought reconsideration contending that having rejected defendant's proposed rating, the WCJ was obliged to award 29%. The WCJ reported that Dr. Korsh's report did not rebut the primary treating physician's opinion, so there was no basis for following the 29% proposed rating, however, the WCJ felt that the 5% was not reflective of the disability described by Dr. Maguire. The WCJ concluded that there was no indication that the legislature intended to replace the requirement that a permanent disability finding be based on substantial evidence, and if he were required to choose between the two proposed ratings, he would have selected the one proposed by defendant. The Board adopted the report and recommendation and denied reconsideration.

3 *Kern High School District v. Workers' Compensation Appeals Board (Fisher)* (2001) 66 CCC 10 (not published).

The injured worker sustained an admitted injury to both upper extremities and was found by the Appeals Board to be 100 percent disabled. The treating physician and another examining physician (the decision inconsistently refers to the second examiner as a Q.M.E. and as an A.M.E.) both agreed applicant was at minimum completely disabled from using her right hand. At the time of the permanent and stationary evaluation, the treating physician noted the patient was beginning to have complaints of pain with activity and at rest in the left hand very similar to the inception of the pain and the disabled right hand. A return to work functional

capacity evaluation report prepared by an Occupational Therapy Evaluator concluded that the applicant was unemployable because of the inception of symptoms in the left hand and resulting in inability to change hand dominates to the left. The treating physician's report, however, was unclear as to whether its conclusion of total disability was based on disability as to both extremities or just as to the right extremity, because the physician stated somewhat inconsistently, that the applicant was unemployable, while at the same time noting that she was only beginning to have symptomatology in the left hand. The physician's opinion did not constitute substantial evidence of total disability.

The Board's opinion did not address the ambiguity, nor state specifically the evidence relied upon in the Opinion on Reconsideration. Two members of the WCAB Panel agreed with the Workers' Compensation Judge that the treaters' reports constituted substantial evidence, and the dissenting opinion concluded that there was an insufficient diagnosis and description of the applicant's permanent disability and recommended further development of the medical record. None of the panel commissioners appeared to have determined that the Q.M.E/A.M.E.'s opinion, that applicant was totally disabled from using the right hand only, was considered.

XV Apportionment

Martinez v. WCAB (2001) 66 CCC 1024 (not published).

The applicant was initially injured in 1984 while working as a sign poster for the County of Los Angeles. He underwent back surgery and was awarded 60% Permanent Disability based upon a limitation to light work. He returned to modified duty in 1986 as an office manager. He continued that job until he was injured again in 1998. In the intervening years from 1986 to 1998 he did not receive any medical treatment, but continued to limit his work activities.

In adjudicating the case, the astute WCJ issued rating instructions that produced a 60% standard rating, based upon the opinion of the applicant's physician, Dennis Ainbinder, M.D., that the applicant was now limited to semi-sedentary work. Despite Dr. Ainbinder's opinion that no apportionment was indicated since Dr. Ainbinder thought the applicant had continued to work in his arduous job as a sign poster after returning to work in 1984, the WCJ nevertheless instructed the rater to consider a pre-existing preclusion from heavy work which resulted in an award of 30% Permanent Disability, after apportionment.

The applicant sought reconsideration, arguing both that he was fully rehabilitated from the 1984 back injury and that the defendant failed to meet its burden of proving the issue of apportionment. In his Report and Recommendation on Reconsideration, the WCJ pointed out that Dr. Ainbinder incorrectly assumed that the applicant had continued to work as sign poster, rather than returning to the lighter duties of office manager.

The Board agreed with the WCJ that the applicant had only partially rehabilitated himself from the 1984 injury and denied reconsideration. The applicant then filed for writ of review arguing that the burden was on the defendant to prove apportionment on the present record, without further development of the record. The court of appeal granted review.

The court pointed out that apportionment of Permanent Disability requires expert medical opinion, and the burden is on the defendant to provide it. *Pullman Kellogg v. WCAB (Normand)* (1980) 45CCC170. The Board, nor the WCJ, has no authority to substitute its own opinion where the opinion from a medical expert is required. Moreover, apportionment is not within the range of evidence when part of that evidence is missing. Here the applicant's physician incorrectly assumed the applicant continued to work as a sign poster. Therefore, the court annulled the WCJ's finding on apportionment.

The court then discussed whether to affirm without apportionment or develop the record further, noting that cases have gone both ways. *King v. WCAB* (1991) 56CCC408. However, to affirm the Board's decision requires substantial evidence, but such evidence is lacking here because of Dr. Ainbinder's error in assuming that the applicant returned to work as a sign poster.

The court pointed out that historically the Board has been obliged to not the leave issue undeveloped when further evidence is required. *West v. IAC (Best*) (1947) 12CCC86. However, the court pointed out in *San Bernardino Hospital v. WCAB (McKernan*) (1999) 64CCC986, that neither the earlier cases nor the recent opinion in *Tyler v. WCAB* (1997) 62CCC924 discuss the potential tension between Labor Code §§5701 and 5906, which permit the WCAB to gather additional evidence, and the more specific language of the subsequently enacted Labor Code §5502(d)(3) which closes discovery on the day of the MSC. The court in *McKernan* pointed out that although Labor Code §5502(d)(3) prevails, the three Labor Code Sections may be compatible where neither side has presented substantial evidence upon which a decision can be based.

In the present case neither party offered substantial evidence sufficient to support a decision on the issue of apportionment, and, therefore, further development of the record is necessary. The matter was remanded for further development of the record.

XVI Death Benefits

XVII Hearings, Discovery Closure, WCJ's development of the record.

1 *Hamilton v. Lockheed Corporation* (2001) 66 CCC 473, 29 CWCR 101(Board En Banc).

The WCJ took a case under submission at the request of the parties and issued a determination based on the opinion of an AME, finding that the applicant was totally disabled, all on an industrial basis. The defendant sought reconsideration, contending that there should have been apportionment of permanent disability, that the entire record had not been considered, and that the defendant had been denied due process of law.

The Board granted reconsideration and returned the case to the WCJ to develop the record and issue a new decision. The Board complained that the case file transferred to them consisted of skeletal minutes and a large collection of documents, including medical reports and depositions that were not listed, identified, or otherwise referred to anywhere in the file. The Board said that on such a record, no reviewing tribunal could understand the basis for the decision in this case.

When a case is submitted for decision on the record, it is the responsibility of the parties and the WCJ to ensure that there is a complete and properly organized record. These responsibilities are set forth in Labor Code §5502.

L. C. §5502(d)(2) requires the WCJ to frame the stipulations and issues. Under L. C. §5502(d)(3) and WCAB Rule §10353, the parties must file a preconference statement setting forth the specific issues that are in dispute and listing the documentary evidence and witnesses. Rule §10353 directs the WCJ to file a summary of conference proceedings, including the joint pre-trial conference statement.

WCAB Rule §10750 sets forth the required contents of the record. This includes pleadings, declarations of readiness, minutes of hearing and summary of evidence, transcripts (if prepared and filed), proofs of service, exhibits admitted in evidence, exhibits marked but not received, notices, petitions, briefs, findings, orders, decisions, and awards.

At the conclusion of every hearing or conference, the WCJ must prepare minutes of the hearing and a summary of the evidence. The minutes must include all interlocutory orders, admissions and stipulations, matters in issue, a descriptive listing of all exhibits, and the disposition. Under Rule §10566, each exhibit must be clearly identified and numbered.

Under L.C. §5313, the WCJ must clearly and concisely set forth the reasons for the decision on each issue in dispute and state the evidence relied upon in making that decision. A suitable opinion on decision informs the parties of the basis for the decision and makes the right to seek reconsideration more effective.

2. *Sheida vs. WCAB* (2001)66 CCC 656 (writ denied).

Applicant injured her low back on January 2, 1998. The parties disputed the level of PD. The WCJ awarded 16 percent PD based on the range of evidence. The applicant sought reconsideration, which was granted, for further development of the record on the issues of applicant's job duties and occupational variant.

The WCAB held a trial, and the parties stipulated and the WCJ agreed that applicant's occupational group was 360. All other issues were submitted, including PD. The WCJ awarded applicant 17 percent PD based on the range of evidence. Applicant sought reconsideration, contending there was no substantial evidence to support the PD finding; that the WCJ should apply the L.C. §4062.9 treating physician presumption to reports of her treating doctor; that the presumption was not overcome; and the WCAB should rate her PD based on the treating doctor.

In his report and recommendation, the WCJ explained that there was a conflict in the expert medical opinion. The treating physician stated that applicant's disability was a preclusion from heavy lifting, repeated bending, and prolonged standing. That disability describes a 35 percent standard disability. On the other hand, the defendant's qualified medical evaluator, Dr. Daniel Wilson, finds the applicant has no ratable permanent disability and currently can work without restrictions.

The WCJ did not find the opinion of either doctor to be completely persuasive as to the extent of applicant's permanent disability. The WCJ found the recommended work restrictions of the treating doctor to be excessive. The WCJ pointed out the applicant sustained a soft tissue injury, a lumbosacral strain, according to treating doctor. The MRI showed no significant findings. The disk bulging at L4-5 and L5-S1 do not affect the spinal cord or individual nerves. The WCJ indicated he believes the applicant experiences some residual subjective complaints from the injury, but in his opinion, they did not justify the significant work restrictions recommended by the treating doctor.

Regarding the QME obtained by the defendants, the WCJ believed that he understated the applicant's residual complaints. The WCJ indicated that the applicant experienced more than occasional minimal pain in the low back as a result of the injury.

Dr. Wilson, the defendant's QME, also discussed at some length his views as to applicant's credibility, or, rather, lack thereof. The doctor questioned the applicant's credibility because she stated that she drove to UCLA from Huntington Beach when she actually lives in Westminster. The applicant testified that she lives in a home with a Westminster mailing address, located near the Westminster-Huntington Beach city limits. Further, the defense doctor concluded that the activities that the applicant is seen performing in the sub rosa films indicate that the applicant had no residual disability.

The sub rosa films show the applicant getting in and out of a motor vehicle on several occasions and decorating the yard for a birthday party, hanging streamers and balloons, not what would be considered arduous work.

The WCJ stated that given the defense QME's extensive commentary on his perception of her lack of credibility, he must question whether the doctor was fair and objective in his evaluation of the applicant. Accordingly, the WCJ felt he could not rely on the opinion of the defense QME in determining the extent of disability.

Upon considering the range of permanent disability found by both doctors, as well as their findings on examination, and the testimony of the applicant, the WCJ believed the applicant had residual permanent disability. The WCJ concluded the applicant's permanent disability fell within the range of evidence presented. The WCJ concluded the applicant should avoid heavy lifting so as to protect her from further injury and to avoid undue increases in subjective complaints. Permanent disability indemnity was awarded accordingly.

The WCJ indicated, after considering the applicant's description of her subjective complaints and her daily activities as a full-time student, that he believed that the work restrictions suggested by the treating doctor were excessive.

The WCJ cited cases of *Liberty Mutual v. IAC (Serafin)* (1998) 13 CCC 267, *Zare v. WCAB* (1998) 63 CCC 1449, and *Fleming v. WCAB* (1998) 63 CCC 762, for the proposition that the WCJ may determine a permanent disability within the range of evidence.

The WCJ addressed L.C. §4062.9 presumption that the treating physician's opinions are presumed correct. The WCJ did not find the treating doctor's opinion about applicant's work restrictions to be persuasive. The WCJ stated the doctor's failure to convince the trier of fact that his assessment of the applicant's permanent disability is reasonable is the basis for overcoming the presumption of L.C. §4062.9.

The WCJ, in coming to his conclusion, considered all the evidence, medical reports, medical records, the applicant's testimony and the surveillance videotapes in determining the nature and extent of applicant's permanent disability. The WCAB denied reconsideration based on a review of the record and adopted and incorporated the WCJ's comments. The writ of review was denied.

3. *Telles Transport, Inc. v. WCAB (Zuniga)* (2001) 66 CCC 1290.

The applicant was employed as a truck driver on September 29, 1999 when he allegedly sustained an injury to his left knee. The employer denied the claim. The applicant received treatment at University Medical Center. Those records were subpoenaed and both parties had them at the time of the MSC. The applicant did not offer the records because they showed inconsistent dates of injury. The WCJ

heard testimony from the applicant as to how the injury occurred and then heard testimony from four coworkers who refuted the applicant's version of events. The WCJ found the claim non-compensable on the basis that the applicant did not meet his burden of proof under L.C. §3202.5. The WCJ noted that since the medical center records were not offered into evidence there was no evidence to corroborate the applicant's claim.

The applicant sought reconsideration, now arguing that the medical records should be allowed in evidence to help support his claim. The Appeals Board granted reconsideration stating that it had a duty to develop the record fully. The defendant then filed for writ of review which was granted.

The appeals court relied on the case of *San Bernardino Community Hospital V. WCAB (McKernan)* (1999) 64 CCC 986 which ruled that the clear and explicit language of L.C. §5502(d)(3) prevails over the more amorphous powers of L.C. §§5701 and 5906. The appeals court found it an abuse of discretion for the Appeals Board to ignore the holding in McKernan. L.C. §5502(d)(3) states that evidence not disclosed at the MSC will not be admissible unless it is shown that it was unavailable or could not have been discovered before the MSC. The appeals court applied the doctrines of waiver and invited error, with the court noting that when a deliberate trial strategy results in an adverse outcome, the attorney may not use that tactical decision to claim prejudicial error. Under the doctrine of waiver a party loses the right to appeal an issue resulting from affirmative conduct or from failure to take proper steps to avoid or correct the error. Under the doctrine of invited error a party is estopped from arguing prejudicial error where its own actions caused the problem. A party can not object to the sufficiency of the evidence in support of a finding against it where the evidence's exclusion was its own doing. The appeals court, in overturning the Appeals Board, holds that the parties duty to disclose all available evidence at the MSC supercedes the WCAB's duty to develop the record.

4. *Winncrest Homes, Inc. v. WCAB (Shepherd*) (2001) 66 CCC 971 (writ denied).

Applicant suffered an admitted injury to her low back and left leg on December 29, 1997. The matter proceeded to trial on November 8, 1999, and the WCJ found applicant was entitled to 100% permanent disability. Defendant sought reconsideration, which was granted. The matter was remanded to the WCJ to obtain further evidence. A second trial was held on August 14, 2000, and submitted for decision on December 15, 2000, with the WCJ, again, finding applicant 100% disabled.

Defendants obtained surveillance videotape of applicant's activities after the second trial. Defendants attached the videotape to the Petition for Reconsideration of the second 100% award. They also attached a copy of the investigator's report and wished the tapes and the report admitted into evidence.

The Workers' Compensation Judge, in his Report and Recommendation on Reconsideration, recommended the surveillance films be excluded because the defendants did not show due diligence in obtaining the videotapes, as required by L.C. §5903(d). The WCJ indicated that the defendants obtained surveillance films of the applicant on September 20 and 24, November 16, 17, 18, 20, 21, 22, December 22 and 23, and January 12, 2001. The judge indicated that all the surveillance films were obtained after the second trial. Six of the days were after the case was submitted. No explanation was given as to why the films were obtained after second trial.

The judge indicated the films did not show anything inconsistent with the applicant's disability. The judge recommended the films not be admitted and reconsideration be denied.

L.C. §5903(d) allows reconsideration if a party can demonstrate that there is newly-discovered material evidence that could not, with reasonable diligence, have been discovered and produced at the hearing. The films in this case are material because they go to the applicant's credibility and extent of her disability. The only question, then, is whether the films could have been obtained with reasonable diligence and produced at the hearing.

The defendants argue it was unable to obtain films of events which had not occurred at the time of the second trial. However, defendants do not contend that they were unable to film the applicant doing the same things, either before the first trial, or in between the order granting reconsideration for the second trial. The defendants also do not contend that they received information about the applicant engaging in these unexpected activities. The films depict low-energy activities of daily living. A reasonable inference can be drawn that the defendants simply decided to get some films to better defend a significant case. None of the offered films were obtained before the second trial.

In the case of *Caputto v. Fireman's Fund* (1998) 26 CWCR, a divided panel analyzed the question of the competing policies of L.C. §5502(d), favoring closure of discovery, while L.C. §5708 favors informality intended to ascertain the substantial rights of the parties. The majority in that case resolved the matter by noting that discovery had been left open after two MSCs for some purposes, and in all fairness it was construed to have been left open for all purposes. The Board distinguished this from the instant case. Discovery was closed on December 2, 1999, and there was only one MSC and trial-setting before the defendants' first Petition for Reconsideration.

In the case of *San Bernardino County Hospital v. WCAB (McKernan)* (1999) 64 CCC 986, the Court of Appeal analyzed the policy behind the Labor Code §5502 requirement that witnesses and exhibits be listed at the MSC. It also criticized the reasoning in *County of Sacramento v. WCAB (Estrada*) (1999) 66 CCC 26, in that

the WCJ admitted further medical evidence without requiring the applicant to show any diligence regarding attempting to timely obtain the medical evidence. *McKernan* also points out that expanding discovery to allow rebuttal of the unlisted evidence may cure the prejudice of admitting that unlisted evidence, but it will frustrate the purpose of L.C. §5502(d)(3) because the WCJ can always expand discovery.

Such an interpretation of L. C. §5502(d)(3) undercuts the other policy behind that section, that both parties should be prepared at the time of the MSC so that they can realistically negotiate with a real chance of success. It was indicated that in the instant case, no excuse is offered why the films being taken into evidence could not have, with due diligence, been discovered prior to the Petition for Reconsideration. The WCJ recommended that reconsideration be granted for the limited purpose of accurately commuting attorney's fees, where the WCJ, earlier, lacked sufficient information to do so and that reconsideration be denied in all other respects. The WCAB granted reconsideration for the limited purposes of commuting the attorney's fee as recommended by the WCJ, and otherwise adopted and incorporated and affirmed the WCJ's decision. The writ was denied.

XVIII Compromise and Release

1. *Jefferson v. State of California Department of Youth Authority* (2001) 66 CCC 343. NOTE: California Supreme Court has granted review, therefore, **case cannot be cited**.

Plaintiff, Mary Jefferson, appealed a judgment entered in favor of the defendant following the trial court's granting the defendant's motion for a summary judgment. The trial court granted the summary judgment on the ground that the plaintiff's sex discrimination claim was barred by a workers' compensation release of all claims. The question here is whether the release in workers' compensation bars the plaintiff's discrimination claim where the general release does not expressly waive her discrimination claim. The plaintiff made alternative arguments that the release was limited solely to the workers' compensation issue and that the release is ambiguous as to whether it included the discrimination claim. The Court says the general release states that the plaintiff waived all claims, and she failed to provide any evidence to the contrary. Even though the release was a preprinted form, that alone does not raise a triable issue as to whether the plaintiff intended to waive civil as well as workers' compensation claims. The release expressly waived all claims related to the underlying injury. There was no language excluding discrimination claims.

The plaintiff was employed by the Youth Authority as a teacher's assistant from September 1992 to February 1994. During that time the teacher and his students allegedly used derogatory language when referring to females, such as "bitch," "whore," and "slut." The plaintiff was offended, so she complained to the teacher and his supervisors, but the conduct continued. As a result of her complaints, in

February 1994, she was told not to return to that teacher's classroom. Two days later her doctor took her off work, due to job-related stress. Two days following that she received a memo reassigning her to a different classroom, but she never returned to work.

In March 1994 the plaintiff filed a workers' compensation claim alleging injury to her psyche, hypertension, and allergies. In her report to the employer, she claimed her injuries were due to sexual harassment from the teacher and his students.

In October 1994 the plaintiff filed a FEHA sex discrimination claim with the Department of Fair Employment and Housing. She alleged in the claim that she was subjected to sex harassment in the work environment. In October 1995, the Department of Fair Employment and Housing sent her a right-to-sue letter.

In July 1996 she settled her workers' compensation claim and signed a compromise and release. She read the release before signing it, and she was represented by counsel at the time. The release included language that the plaintiff forever discharged the employer from all claims and causes of action, whether now known or ascertained, or which may hereafter arise or develop as a result of said injury. The settlement stated: "Applicant agrees that this release will apply to all unknown and unanticipated injuries and damages resulting from such accident, and all rights under Section 1542 of the Civil Code of California are hereby expressly waived."

The applicant resigned her employment with the Youth Authority in June 1996, because she believed the employer would not settle with her unless she did so. In August 1996 the Compromise and Release was approved. The plaintiff filed her civil lawsuit against the Youth Authority three weeks later. The defendant then filed a motion for summary judgment as to the FEHA action.

The trial court granted the motion on the ground that the Compromise and Release barred her complaint as a matter of law, even though the release was clearly outside the scope of workers' compensation. Having accepted the $49,500 settlement amount, the court found the plaintiff could not avoid the express terms of the release. The plaintiff appealed.

Generally, a written release extinguishes any obligation covered by its terms, provided it has not been obtained by fraud, deception, misrepresentation, duress, or undue influence. When a person capable of reading and understanding a release signs it, then he or she is bound by its provisions and is estopped from claiming they are contrary to his or her understanding or intentions. Assent to a release agreement is necessary for the release to be binding. Here, the plaintiff claims she never intended to abandon her FEHA discrimination claim. The Court says it will enforce the outward expression of the agreement, rather than a party's unexpressed intentions. Even though the plaintiff intended to release only the workers' compensation claim, she did not say so in the release. Here, there was no evidence

that any party discussed whether the release would encompass the FEHA claim or not. The release, in this case, also released co-employees, which indicates the release was intended to encompass civil claims as well.

The Court, here, overrules the holding in *Delaney v. Superior Fast Freight* (1993) 14 Cal.App.4th 590. The only difference between *Delaney* and the case at bar is that the release in *Delaney* did not include a clause also releasing co-workers from liability. The Court says they specifically disagree with the holding in *Delaney* regarding whether a workers' compensation release encompasses a civil claim, stating that *Delaney* lacks any authority to support the conclusions made. *Delaney* is not well founded in either case law or statutory authority. Instead, the case law says that when the releasor is aware of a claim that he does not intend to release, he has a duty to so specify in the written release.

The Court, here, says they decline to rewrite the appellant's release agreement to include a concept she failed to enunciate at the time she accepted the terms of the agreement with the employer. The Court, here, finds the release to be complete, explicit, and as unambiguous as a general release can be. The Court says it is a beneficial principle of contract law that general releases can be constructed so as to be completely enforceable.

The Court says the fact that the settlement was brought in the workers' compensation forum does not render the general release inapplicable to claims in other forums. To conclude otherwise would result in the erosion of the effectiveness, reliability, and predictability of a general release. Parties would be deprived of the peace of mind such a release is intended to bring. The Court says that if a releasor is aware of other claims in other forums, the burden is on them to specify in the release the nonrelinquishment of such claims.

The Court reiterated that plaintiff's claim was barred by the general release, and the judgment of the Superior Court was affirmed.

2. *Sandbloom v. Shasta County Sheriff's Department* (2001) 29 CWCR 282 (Board Panel Decision).

Applicant, a Shasta County Deputy Sheriff, died from cancer on March 22, 2000. His widow and two adult children filed an application for death benefits, alleging the cancer arose out of and occurred in the course of his employment. The defendant, permissibly self-insured, denied liability. The matter proceeded to a mandatory settlement conference. At the mandatory settlement conference, an attorney appeared on behalf of defendants, and the claims administrator was available by telephone. They had authority to settle the claim for up to $50,000.

By a resolution in 1992, the Shasta County Board of Supervisors had adopted an administrative manual of provisions establishing procedures for handling claims involving the County and its employees. The County risk manager was authorized

to manage and oversee workers' compensation claims and to pay all necessary medical, rehabilitation, adjusting and litigation expenses. The risk manager was also authorized to settle workers' compensation claims for up to $20,000. That section was later amended to read $50,000.

At the MSC, applicant and defendants agreed to Compromise and Release the case for $60,000. That included a provision allowing defense counsel 30 days to secure authority from the Board of Supervisors. The WCJ refused to accept the C&R with this provision and scheduled the case for formal hearing on all issues before a different WCJ. The WCJ then issued an order that defendant and its claims administrator show cause why they should not be found in contempt and sanctioned for violation of WCAB Rule §10563.

Defendant's claims administrator, meanwhile, secured approval of the $60,000 settlement at the next meeting of the Board of Supervisors, and the Compromise and Release was submitted to another WCJ, who approved it and cancelled the formal hearing.

Three days later the WCJ who had conducted the mandatory settlement conference issued an order that both defendant, County of Shasta, and their claims management representative be cited for contempt for violation of WCAB Rule §10563 and a hearing held on said issue and any mitigation. It was further ordered that both the County of Shasta and their claims representative be sanctioned for a bad faith delay of the case.

Defendant petitioned for reconsideration or, in the alternative, removal, contending that persons with settlement authority to the fullest extent allowed by law were present at the MSC as required by WCAB Rule §10563 and that having exhausted the authority delegated by the Board of Supervisors under the Government Code, defense counsel continued negotiations that resulted in an approved settlement requiring approval by the Board of Supervisors, approval was promptly obtained, and the C&R approved in less than 30 days and defendant was not, therefore, guilty of any contemptuous or sanctionable conduct.

A Board panel concluded that reconsideration was not appropriate, but that the facts warranted removal. The Board concluded that disobedience of a lawful order or process of the Board is contempt but that defendant had not violated WCAB Rule §10563, nor any lawful process of the WCAB.

Similarly, the panel found no basis for ordering sanctions against either defendant or the claims administrator pursuant to L.C. §5813. The Board concluded that nothing in defendant's conduct constituted bad faith, intentional delay, or any other sanctionable offense. The procedure followed by the defendant was the customary procedure prescribed by law for the counties. A person was available at the time of the MSC with settlement authority up to the $50,000 maximum permitted by law. Authorization by the Board of Supervisors was necessary for any settlement

beyond that amount. Defendant promptly secured the consent and submitted the $60,000 C&R for WCAB approval within three weeks. There was no bad faith or willful intent to delay on defendant's part.

Accordingly, the panel dismissed the petition for reconsideration, granted the petition for removal, and rescinded the order under attack.

XIX Findings and Awards and Orders

XX Reconsideration

XXI Judicial Review

Kemper Ins. Co. v. WCAB (Gudino) (2001) 66 CCC 1024 (not published).

The applicant alleged an industrial back injury on February 24, 1997. He did not report the injury to his supervisor, but he soon underwent medical treatment and later filed a claim, purportedly after the employer's plant nurse refused to give him a claim form.

The applicant's attorney sent him to Mark Greenspan, M.D., who found industrial causation and entitlement to temporary disability, permanent disability, and further medical treatment. The defendant's doctor, Steven Silbart, M.D., reported that the applicant was suffering from a nonindustrial herniated disc. After reviewing the applicant's medical records from previous claims, Dr. Silbart reported that the applicant was not a credible historian.

The WCJ found the applicant to be a highly credible witness and found the injury compensable under the presumption of L. C. § 5402. The WCJ opined that any discrepancy between the applicant's testimony and the history contained in the medical record was merely a function of how the questions were asked. The WCJ issued an award of Temporary Disability, of 27 _ % Permanent Disability, and of medical treatment.

The defendant sought reconsideration which the Board granted. They held that the L. C. §5402 presumption did not apply where the evidence respecting the defendant's failure to provide a claim form was vague and, furthermore, the injury was timely denied after the applicant submitted a claim form. The Board found that, nevertheless, the evidence did support a finding of injury, noting that while there was a history of prior back problems and treatment, there was no evidence of herniated disc prior to February 24, 1997. The defendant then filed for writ of review, contending that the applicant's report from Dr. Greenspan was not substantial evidence because he did not review all of the prior medical records and that the applicant gave a false history and perjured testimony, which should result

in a finding against him on the issue of injury. Based on those allegations the court of appeal granted review.

The court set forth the standard for review, noting that the decision of the Board must be affirmed if supported by substantial evidence in light of the entire record, that the court may not reweigh the evidence, and that all reasonable doubts as to whether the injury is industrial for not must be resolved in favor of the applicant. They pointed out that the WCJ's findings on credibility are entitled to great weight. After considering the entire record the court stated that the WCJ's findings as to the applicant's credibility was reasonable given the complex medical history and the number of years the applicant was without complaints prior to the present injury.

The court pointed out that the defendant omitted supplemental reports from Dr. Greenspan and failed to fairly state all the material evidence relative to the issue of substantial evidence when they filed their petition for writ of review. This violates California Rules of Court, Rule 57(a) and it misled the court into granting review. Accordingly, the court vacated the order granting review, denied the petition for review, and affirmed the Board's decision.

XXII Reopening

Hernandez-Negrete v. County of San Bernardino (2001) 29 CWCR 131 (Board Panel Decision).

Applicant injured her back in the course of her employment as a Deputy Sheriff. Applicant sustained a subsequent cumulative back injury. In 1998, it was found that the two injuries had caused a combined permanent disability of 47 percent. On September 21, 1998 applicant petitioned to reopen the cumulative injury claim, alleging that she had received additional medical treatment and been temporarily disabled.

At the hearing on the petition to reopen, a 1999 report from the primary treating physician attributed applicant's disability to the 1992 specific injury. The reports of a qualified medical evaluator selected by the employer expressed the opinion that there was no cumulative trauma and that any increase in applicant's disability was only temporary. On October 23, 2000, the WCJ awarded additional compensation. Defendant sought reconsideration, which was granted.

In its decision after reconsideration, a Board panel discussed the law on reopening where there have been two injuries, but only one is the subject of being reopened because more than five years has passed. The panel returned the case to the WCJ for further proceedings.

At the hearing on remand, the WCJ indicated that his new decision would be essentially the same as the one he had issued on October 23, 2000. The defendant

petitioned the Board for an order removing the case to itself pursuant to L. C. §5310, arguing that it was prejudiced by the WCJ's comments. The WCJ's report on petition for removal said that the original injury was simply the initial insult and that it was applicant's work thereafter that caused the subsequent disability and need for surgery.

A Board panel noted that the exercise of the power granted in L. C. §5310 is discretionary and employed only when the party establishes that substantial prejudice or irreparable harm will result if the case is not removed to the Board. It can be used for resolving certain issues, such as discovery or venue disputes, but it is not available to resolve the very issue that is pending before the WCJ.

The panel added that it was taking no position on how the case should be decided, but pointed out that although a WCJ may rely on the opinion of a single physician, there must be substantial evidence to support a decision. On issues requiring expert medical opinion, the trier of fact must base the decision on the medical evidence and may not substitute lay opinion.

XXIII Statute of Limitations

Hampton v. WCAB (2001) 66 CCC 1269.

While employed during the period from 1963 to 1982 the applicant sustained an admitted injury to his right knee on April 26, 1977 where he lost five or six weeks of work and an admitted injury to his left knee on March 9, 1978 where he lost six to seven weeks of work. The employer paid for his medical treatment and paid temporary disability indemnity. The employer's plant closed in 1982. While still in California he was hired by the same employer to work in Missouri where he worked until 1987. The employer provided him with treatment for his knees at the plant dispensary.

In 1989 the employer transferred the applicant to Portland, Oregon where he worked until he retired on August 1, 1994. In 1991 he consulted a doctor who told him to file a Workers Compensation claim. He did so in Oregon, claiming aggravation of the knee injuries of 1977 and 1978.

The employer paid for treatment and paid T.T.D in August and September 1991 before eventually denying the claim.

The employer obtained a medical/legal report in Portland wherein the doctor found the knee conditions related to the specific injuries of 1977 and 1978. Thereafter, the Oregon Workers Compensation Board upheld the employer's denial of the claims.

On August 10, 1992 the applicant filed claims for the two specific injuries in California. On October 13, 1993 he filed a third claim alleging a cumulative trauma

injury to his legs and knees during the California jurisdictional period of his employment for the period from 1963 to 1987, his last date of employment in Missouri.

The cases were heard in 1996 and the WCJ found that the defendant was estopped to raise the Statute of Limitations defense as to the two specific injuries because they failed to establish that the applicant was provided with the necessary statutory notices from the employer of his right to file claims.

On reconsideration the Appeals Board reversed the WCJ, holding that the applicant did not adequately prove that the employer failed to send the requisite notices. Instead, the Board relied on testimony of the defense witness that it is their practice to send out such notices, but by now the plant was long closed and those records were destroyed. The Board also held that the cumulative trauma claim was barred by the Statute of Limitation, relying on the July 1, 1992 opinion of the Oregon Board which stated "this must be considered on occupational disease case".

Now the applicant filed for reconsideration, but it was dismissed as being untimely filed.

The appeals court granted the applicant's petition for writ of review and remanded the matter to the Appeals Board for a hearing on the merits. In a 2 to 1 decision the Board upheld it's previous ruling and again the applicant petitioned for writ of review.

The court states that the employer bears the burden of proof with respect to the Statute of Limitations defense. The inference that they sent the required termination of benefit notices to the applicant is unsupported. The employer could provide no evidence pertaining to the applicant's claims in 1977 and 1978. The employer witness had no personal knowledge of the claims. The claims adjuster did not testify. The applicant credibly testified that he received no termination of benefit notice advising him of his right to pursue a Workers Compensation claim. The court pointed out that under L.C. §3202 it was mandated to liberally construe the Workers Compensation Act with the purpose of extending benefits. Here there was no substantial evidence that the employer actually sent out the "Reynolds" notice. Therefore, the Statute of Limitations defense does not apply to the specific injury claims.

As to the cumulative trauma claim the appeals court found that the decision of the Oregon Compensation Board that applicant's claim must be considered to be an occupational disease case to be ambiguous and insufficient to establish the required knowledge under L.C. §5412. The court pointed out that the applicant thought his injuries were due to the specifics in 1977 and 1978. The medical reports from the doctors in Portland did not mention a cumulative trauma injury. The first medical evidence supporting a cumulative trauma claim was not produced until 1994.

Therefore, the Statute of Limitations defense is not available as to the cumulative trauma claim.

XXIV Contribution

XXV Subrogation, Third Party Actions

1. *Camargo v. Tjaarda Dairy* (2001) 66 CCC 843.

The employee died when his tractor rolled over as he was driving over a big mound of manure at the dairy. The decedent was a full-time employee of Golden Cal Trucking, which the dairy had hired to scrape manure out of its corrals and haul it away in exchange for the right to buy the manure at a discount. The trucking company then resells the manure for use as fertilizer.

The widow and dependent children filed a workers' compensation claim against the trucking company, from whom they collected benefits. They then filed a suit in Superior Court against the dairy alleging that the injury was caused by the contractor's negligent performance. The claim was that the tractor was not property equipped with roll bars and safety restraints, making the contractor unqualified for the job. The theory of negligence as against the dairy is that, in hiring the trucking company, they failed to make sure the trucking company was qualified for the job.

Since 1993, California courts have barred workers of contractors from suing firms that hired the contractors for work that was inherently dangerous. In this case, the dairy argued that it would be unfair if the hirer were liable for substantial damages when the firm that employed the worker could not be sued.

The Supreme Court concluded that the hirer should not have to pay for injuries caused by the contractor's negligent performance, because the workers' compensation system already covers those injuries.

2. *Kinney v. CSB Construction, Inc.* (2001) 66 CCC 28.

The plaintiff sustained injury when he fell 15 feet while working as an ironworker employed by subcontractor, P. B. Erectors (PBE). Plaintiff filed a civil action against the general contractor, CSB Construction, Inc., alleging the general contractor failed to require its subcontractor to take safety precautions in the construction of a building at the Bay Meadows Racetrack.

The contract between the owner and CSB required CSB to maintain safety and loss prevention programs. The subcontract between CSB and PBE required PBE to supply at its cost all labor equipment, scaffolding, materials, supervision, and other things necessary to complete the work, and, additionally required PBE to timely perform all obligations owed by CSB to the owner. Plaintiff Kinney received

instructions from his foreman, an employee of PBE. Plaintiff received workers' compensation benefits through the PBE policy. The evidence at trial showed that CSB took no action to create or increase the risks on the job. The mere failure to exercise a power to compel the subcontractor to adopt safer procedures does not establish a duty of care on the part of the general contractor to the employee of a subcontractor. Defendant CSB had no duty in tort to correct the unsafe practices or conditions on the part of PBE, which plaintiff contended caused his injuries. Summary judgment in favor of the general contractor CSB was affirmed.

XXVI Credit, Restitution, Fraud

1. *Adecco Employment Services v. Workers' Compensation Appeals Board (Mendez)* (2001) 66 CCC 143 (writ denied).

Applicant sustained an admitted industrial injury to his left shoulder, neck and left knee. He was evaluated by an AME. Applicant presented himself as having a severely limited range of motion and mobility. He denied having done any gardening work since the date of injury. The AME issued an initial report in which he remarked that the clinical examination was complicated by significant embellishment. Later, the AME was presented with *sub rosa* video of applicant taken six days before the evaluation. In the film, applicant was caught gardening, which included digging and breaking up dirt with a shovel, carrying and lowering an approximately five gallon potted plant, planting plants, repetitive bending and stooping, use of the left upper extremity overhead, lifting a small child overhead, utilizing a full range of motion of the neck, among physical activities. At his deposition, the AME, opined that the applicant had made conscious misrepresentations, both verbally and physically, about his condition.

The WCJ found that applicant had made false representations, and, by making false representations, applicant had violated Insurance Code §18924 and was, therefore, barred from any receipt of benefits pursuant to Insurance Code §1871.5.

Applicant petitioned for reconsideration. He contended that the WCJ had abused his discretion by finding that applicant has violated the Insurance Code sections and that the applicant had to be criminally convicted before his benefits could be barred under these sections. The Board granted reconsideration and rescinded the Findings and Award and returned the case to the trial level for further proceedings and decision. The Board noted that Insurance Code §§1871.4 and 1871.5 required a criminal conviction prior to any action by WCJ pursuant to these sections. The Board noted that in *Tensfeldt v. Workers Compensation Appeals Board* (1998) 63 CCC 973, where the applicant was barred from receiving workers' compensation benefits, he had previously been convicted of insurance fraud under Insurance Code § 1871.4 in a criminal proceeding. The Board panel concluded that, while applicant may be an exaggerator or malingerer, he had not been convicted of violating the Insurance Code sections or the Penal Code sections and the WCJ did not have jurisdiction to bar his benefit. However, the panel also observed that although the

WCAB lacks jurisdiction to determine fraud under Insurance Code §1871.4, the WCAB can find fraud and on that basis can determine that either there is no industrial injury or the disability and the need for medical treatment is not as extensive as the applicant claims.

Defendant filed a Petition for Writ of Review. Applicant filed an answer rebutting defendant's contentions and requesting attorney fees. The Writ was denied, and applicant's request for supplemental L. C. §5801 attorney fees was granted, and applicant's additional request for penalties and interest was denied. The Court of Appeal found no reasonable basis for the Petition for Writ of Review filed by the employer and remanded the cause to the Board for the purpose of making a supplemental award of reasonable attorney fees to the applicant's attorneys for responding, based upon services rendered in connection with the Petition for Writ of Review. The Court indicated that such fee shall be in addition to the amount of compensation otherwise recoverable and shall be paid as part of the award by the party liable to pay such award.

2. *People v. O'Casey* (2001) 66 CCC 464, 29 CWCR 97.

The claimant allegedly sustained a back injury due to a fall in May 1996. She received workers' compensation benefits; but after further investigation, the carrier denied the claim as being fraudulent, and criminal charges were brought against the claimant. She pleaded no contest to fraud under Insurance Code §1871.4. She was sentenced to probation along with a short jail term, and she was ordered to pay direct restitution to the workers' compensation carrier.

The claimant objected to the restitution order because the statutes authorize restitution only to direct victims. The claimant argued that the employer is the direct victim of her fraud, not the insurance carrier. She argues that her restitution liability is limited to the amount of any deductible paid by the employer to the compensation carrier. The trial court disagreed with the claimant's position, holding that the compensation carrier suffered a loss by making direct compensation payments resulting from the claimant's fraud rather than by reimbursing the employer for crime losses.

On appeal, the court pointed out that the claimant did not admit to fraudulently seeking the employer's property, but to making fraudulent misrepresentations to obtain workers' compensation benefits, which are items of monetary value furnished by the insurance carrier. Furthermore, Insurance Code §1871.4(b) expressly provides for restitution on conviction of workers' compensation fraud, which damages employers by elevating compensation costs and damages workers by undermining the perceptions of the legitimacy of claims. In contrast, it is the carrier who suffers direct harm by incurring the cost of the benefits paid out for the fraudulent claim.

The court affirmed the judgement and ordered the claimant to pay restitution to the workers' compensation carrier.

3. *Torres-Hernandez v. Golden Eagle Insurance Co. (*2001) (WCAB Panel Decision) 29 CWCR 13.

Applicant sustained an admitted injury to his back. Applicant was evaluated by Dr. Dodge, whom he told that he could not shovel or lift. Defendant obtained surveillance film of applicant's activity that clearly showed him lifting and shoveling. Applicant was subsequently charged with and pled guilty to fraudulently misrepresenting his ability to lift and shovel. He was convicted and ordered to make restitution to defendant in the sum of $18,148.34. Thereafter, applicant sought a permanent disability award. At the hearing, the applicant testified to the circumstances surrounding his fraud conviction and admitted that contrary to what he had told Dr. Dodge he could and did lift and shovel. A medical-legal evaluation by a Dr. Markarian and a supplemental report from Dr. Dodge, in which he revised his opinion after seeing the films were received in evidence. The WCJ found the injury caused a 6 3/4 permanent disability and awarded $2,835.00 plus medical-legal costs of $874.30. Defendant was allowed a credit of $536.03 that they had advanced in anticipation of the permanent disability award. Defendant sought reconsideration.

In his report on reconsideration, the WCJ said that pursuant to *Tensfeldt v. WCAB* (1998) 63 CCC 973, applicant was not precluded from receiving a permanent disability award. *Tensfeldt* said that the entitlement to further benefits after a fraud conviction requires (1) an otherwise compensable injury, (2) substantial supporting medical evidence that does not rely on the fraudulent misrepresentation, (3) that applicant's credibility was not so destroyed as to make his testimony wholly reliable. In the opinion of the judge, the award in this case satisfied those requirements. The judge indicated that defendant admitted the industrial injury. The judge further indicated that Dr. Dodge's supplemental report was independent of the fraudulent statement because he revised his permanent disability evaluation after reviewing the films that were the basis for the fraud conviction. In the opinion of the judge, the permanent disability award was based on the uncontroverted opinion the doctor reached after considering the import of the fraudulent misrepresentation. The judge pointed out that the defendant neither objected to Dr. Dodge's later evaluation nor sought a qualified medical evaluation. Finally, in the judge's opinion, the credibility of the applicant was not completely destroyed. He readily acknowledged his fraud conviction and the accuracy of the films. Turning to the effect of the Superior Court order, the WCJ said the defendant had neither established the applicant was in arrears on that obligation, nor what benefits were covered by that order. Defendant was allowed a credit for the permanent disability advances that it made before the conviction. In the judge's opinion defendant had not provided any support for its argument that the Superior Court essentially found the applicant's fraud went to all classes of benefits that had been paid, including permanent disability.

The judge rejected the defendant's argument of collateral estoppel on the Superior Court award. In the opinion of the judge, the issues before the Superior Court and WCAB were not the same. The judge found there was no commonality between the elements of the criminal charge of insurance fraud and the issuance of permanent disability. Finally, the judge indicated that the enforcement of the restitution order was a matter within the jurisdiction of the Superior Court. If the applicant does not comply with the order, the terms of his probation may be revoked or modified. The judge indicated that although he did ignore petitioner's lien claim, it was not distinguishable from the claim for credit on which he did act. In his opinion, a party cannot have a lien against itself, and a lien for an order of restitution is not included among the lien claims authorized by L. C. §4903. A panel, in a 2 to 1 decision, adopted the WCJ's reasoning and denied reconsideration.

XXVII Special Benefits, Including Discrimination Under L. C. §132(a).

1. *Ashbrook v. Vons Companies* (2001) 29 CWCR 284 (Board Panel Decision).

Applicant was employed by defendant as a grocery clerk for 22 years prior to experiencing discomfort in her left hand. She reported it to the self-insured employer, and her supervisor accompanied her to a physician designated by the defendant. She was given not only treatment for the hand, but also a drug test, which was positive for marijuana. Defendants accepted liability for the injury and applicant participated in a drug education program sponsored and paid for by the defendant. When she returned to work, she signed an agreement that required her to submit to random drug testing. She tested positive for methamphetamine and was subsequently terminated.

There was no suspicion that applicant had been using any illegal substance before the injury. The employee guides and manuals given to the employees set forth a drug testing policy and procedure. The guide stated that employees who are involved in a work-related accident/injury as outlined in the policy will be asked to take a drug/alcohol test. Employees who are asked to be drug tested will be referred to a company-designated medical facility for urine analysis. The tests will be performed at a laboratory that is certified by the National Institute on Drug Abuse.

The accidents or injuries for which the testing was required were defined in two places in the guide as follows: An accident resulting in a fatality or an injury to one or more individuals that requires medical treatment by a medical professional. Elsewhere the guide also provided that it is a direct violation of company policy to report to work under the influence of a controlled substance. Therefore, if a manager or supervisor or other person acting in a management capacity and a witness establish reasonable suspicion or probable cause that an employee may be under the influence of a controlled substance, the employee may be asked to submit to a drug test.

An application was filed for normal workers' compensation benefits and for increased benefits, contending that defendant discriminated against the applicant pursuant to L.C. §132a by requiring her to submit to a drug test after her industrial injury and by terminating her after requiring another test when she returned to work. The normal issues were resolved by a stipulated finding that the applicant had sustained an industrial injury. The matter then proceeded to trial on the issue of the L.C. §132a violation.

The WCJ made a finding that defendant had not unlawfully discriminated against applicant in violation of L.C. §132a. Applicant sought reconsideration, contending that requiring applicant to submit to a drug test without reasonable suspicion was a violation of defendant's own policy, defendant's drug policy was discriminatory and illegal, and the second drug test was improper because it was fruit of the poisonous tree, and the supervisor's accompanying applicant to the doctor was discriminatory and illegal.

In his report and recommendation on reconsideration, the WCJ said that applicant's argument that reasonable suspicion was required under defendant's drug policy was based on a misinterpretation of the guide. The test in this case was performed pursuant to the provision relating to testing after accident or injury. The guide also had a policy allowing for testing under other circumstances, including reasonable suspicion. However, the guide provided that a qualifying accident or injury was an independent ground to administer a drug test. The judge concluded that the applicant had a qualifying accident or injury that required a drug test under the policy.

The WCJ, next turned to the question of whether testing without reasonable suspicion was illegal. The WCJ cited Hill v. NCAA (1994) 7C 4th 1 for the proposition that drug testing is appropriate in the case of student athletes because coaches, trainers, and physicians must know intimate details of athletes' medical conditions.

Although the WCJ was unable to find any workers' compensation case, the Court of Appeal, in approving preemployment testing in Wilkinson v. Times Mirror (1989) 215 CA 3d 1034, said that requiring a urine sample for drug testing was only a slight additional intrusion over that inherent in a preemployment physical examination. Here, the applicant was going for medical treatment that was going to require physical examination and medical history. The applicant knew, or should have known, that drug testing would be required pursuant to the company drug policy statement that the applicant had received.

The WCJ then concluded that the drug test administered the first time was proper and legal. The judge then concluded that because the first drug test was proper and legal, there was no poisonous tree as to the second drug test. Therefore, in the

WCJ's opinion, the applicant was terminated for drug use and that was not discriminatory.

Finally, the WCJ found no evidence of any harm to applicant from the supervisor accompanying her to the doctor's office. That act was not one of those made illegal by L.C. §132a and was not without a valid purpose. The supervisor had a legitimate reason to ascertain applicant's work limitations and whether he would be able to provide her with modified work.

Reconsideration was granted by the Appeals Board, and the matter was returned to the WCJ to determine whether the case required interpretation of the provisions of the collective bargaining agreement between Vons and the applicant's union and whether the alleged discrimination issue was one preempted by the National Labor Relations Act.

At the hearing following remand, the parties stipulated that a witness would testify that the drug testing policy was part of the union contract and the union had agreed to it. The parties also stated that neither of them was raising the issue of federal preemption, and neither offered a copy of the collective bargaining agreement. Defendants did not produce a copy of a side agreement and cover letter stating that defendant would handle reasonable suspicion cases the same as post-accident cases.

The WCJ found that the action was preempted by federal law. He reasoned that the parties could not stipulate to jurisdiction that the WCJ did not have.

Applicant again petitioned for reconsideration. The applicant petitioned for reconsideration, raising the issues previously raised and contending that the preemption issue had been waived by failure to assert it and the collective bargaining agreement did not authorize drug testing in the absence of reasonable suspicion.

A board panel agreed that the preemption issue had been waived. Turning to the merits of applicant's claim for increased benefits, the panel said the WCJ's reasoning on the discrimination issue was fully set forth in his first opinion on decision and the report and recommendation on the first petition for reconsideration. Adopting this reasoning, the panel reinstated and reaffirmed the finding as its decision after reconsideration.

The panel explained the documentary evidence established that all employees were subject to drug testing after a qualifying injury or accident. Although there was additional provision for testing where there was reasonable suspicion of drug use, the drug policy did not require that there be reasonable suspicion that an injury or accident was caused by drug use for testing after an injury or accident. Applicant sustained industrial injuries that required medical treatment. In conformity with its

policy, the defendant required the applicant to take the drug test. There was no evidence that defendant deviated from that policy in the applicant's case.

Accordingly, the panel granted reconsideration, rescinded the WCJ's preemption finding, ordered the WCAB's first decision reinstated, and affirmed.

2. *City of Sacramento v. WCAB (Saylors*) certified for publication, Court of Appeal, Third Appellate District, (C037880) (2002).

The City of Sacramento filed a writ of review to overturn a decision of the WCAB which held that an employee of the City as a fire recruit was entitled to L.C. §4850 benefits. The City contends that fire recruits do not engage in firefighting and are not entitled to L.C. §4850 benefits. The Court of Appeal granted review and annulled the decision and found that firefighter recruits are not firefighters and not, therefore, entitled to L.C. §4850 benefits.

The applicant injured his back during a training exercise as a fire recruit for the City. A recruit completes a 16-week training course at the academy which qualifies them to become a probationary status firefighter or firefighter paramedic. The training includes classroom instruction, participation in ground exercises, and live fire exercises.

The live fire training exercises are the last phase of the training and consist of a three-day session in which the recruits are taught how to attack and extinguish a fire and how to search a building for victims. Their ability to handle fire conditions and to withstand heat is determined during this phase. The training involves a closely controlled live fire in an empty brick building, simulating a two-bedroom, one-bath house using hay and wood pallets as fuel.

The WCJ found that a fire recruit is a classification different in kind than that of a firefighter because a recruit's function is to learn rather than to act on the front lines in firefighting or suppression. WCJ ruled the applicant was not entitled to L.C. §4850 benefits. The applicant filed a petition for reconsideration and the Appeals Board reversed and allowed the L.C. §4850 benefits.

The sole question presented the Court of Appeal was whether a fire recruit is a firefighter under L.C. §4850. The Court stated that firefighters are defined as employees of the fire department actively engaged in firefighting and fire prevention services. They are covered by L.C. §4850. All other employees of the fire department are excluded from coverage.

According to the City's job description, a firefighter is one who protects life and property by combatting, extinguishing, and preventing fires and performing emergency medical assistance. The distinguishing characteristics of a firefighter are that it is a journey-level classification. Incumbents are expected to perform the full duties of a firefighter. By contrast, a fire recruit is one who attends and

participates in the Sacramento Fire Training Academy in order to receive the basic training in firefighting methods, equipment operation, medical aid, and physical fitness.

Applying the functional test, a fire recruit's function is to learn the knowledge and skills of a firefighter. Fire recruits do not undertake hazards on behalf of the public. They do not engage in firefighting and prevention services, they do not perform emergency duties involving hazardous materials, nor do they provide medical assistance that might subject them to contagious diseases. While their training involves some degree of risk not encountered by remote support personnel, recruits are not subjected to the same risks as firefighters.

Based upon the clear language and purpose of the statute, the City's job classifications and descriptions, and the evidence, fire recruits are not firefighters entitled to L.C. §4850 benefits.

3. *Currie v. WCAB (Los Angeles County MTA)* (2001) 66 CCC 208.

The Supreme Court has determined that the Workers' Compensation Appeals Board must include pre-judgment interest on lost wages awarded pursuant to L.C. §132a. A bus driver who was terminated from employment for exceeding the leave permitted under his union contract was cleared for regular work following termination. The Workers' Compensation Judge found that the employer's refusal to reinstate the driver when he was cleared for regular work violated L.C. §132a. Applicant was awarded back pay with pre-judgment interest payable from the dates of accrual of the lost wages. The WCJ noted that the employer had the use of applicant's unpaid wages for a lengthy period. On reconsideration, the Appeals Board declared that L. C. §5800 allows only post-judgment interest on 132a awards and reversed the award of pre-judgment interest.

The Supreme Court explained that L. C. §5800 (which provides for post-judgment interest on any award of the Appeals Board "either for the payment of compensation or for the payment of death benefits") does not apply to an award of back pay under L. C. §132a because the "reimbursement for lost wages" provision in L. C. §132a is not "payment of compensation or payment of death benefits." The Court noted that L. C. §132a is in division 1 of the Labor Code and the definition of compensation is in division 4 of the Labor Code. The division 4 definition, located in section 3207, specifically states that "compensation means compensation under division 4 and includes every benefit or payment conferred by division 4. . . ." The Court explained that L. C. §132a back pay liability is not "compensation" within that definition, and with reference to the case of *City of Moorpark v. Superior Court* (1998) 18 Cal.4th 1143 (in which it was found that section 132a is not the exclusive remedy for employment discrimination based on industrial disability), the Court confirmed that the exclusive remedy provisions of the Labor Code only apply to "division 4" benefits.

The authority for an award of pre-judgment interest is found in Civil Code §3287. Awards of back pay are generally considered "damages" within the meaning of that statute. An award of pre-judgment interest has frequently been applied to retroactive awards of government-assisted wages or retirement benefits as applied by other administrative agencies. As with the other agencies, back pay awarded by the WCAB may be considered "damages" for the purpose of the mandatory interest provisions of Civil Code §3287.

The Court further noted that the purpose of L. C. §132a is that there should not be discrimination against workers injured in the course of employment. The construction of the statute adopted by the Court serves its intended function by providing injured workers the pre-judgment interest mandated by Civil Code §3287. The Court held that the Legislature left application of that provision to the equitable discretion of the WCAB. Without the pre-judgment interest, the back pay remedy might lose a significant portion of its value, and the employee would be left less than fully reimbursed for his or her lost wages. The Court rejected the warning of the employer that the decision would open the door to WCAB awards of punitive damages or damages for emotional distress. The fact that pre-judgment interest may be awarded to insure the full benefits provided by L. C. §132a does not suggest that the WCAB has the authority to award damages of types not mentioned in L. C. §132a which are generally reserved to the civil courts.

In a single dissenting opinion Justice Brown asserted that Civil Code §3287 applies only to persons entitled to recover "damages" and that the Civil Code definition of damages is much more broad than the benefits available under L. C. §132a. The dissent cited several Court of Appeal decisions describing L. C. §132a as a provision which creates a right to "benefits" and indicated there is no case that makes reference to "section 132a damages". Although the same discriminatory act may give right to claims for damages under other provisions of law, the dissent maintained damages are not available under L. C. §132a, and accordingly an award of pre-judgment interest would be beyond statutory authority.

4. *Fredrickson v. Parr Lumber Company* (2001) 29 CWCR 255 (Board Panel Decision).

A load of plywood from a forklift being operated by another employee fell on the applicant, causing serious injury. The applicant was standing in the lumberyard when the coemployee, who had operated the forklift for over five years, drove near them with the load of plywood on raised tines. As the lift truck turned, the load shifted and fell on the applicant.

The defendant accepted liability for the injury and stipulated to 77 percent permanent disability and medical treatment. The applicant filed a claim against the employer for increased benefits, alleging that the injury was caused by the company's serious and willful misconduct consisting of failure to provide a safe place to work and violation of a safety order that required every employer using a

forklift and other industrial trucks to post and enforce a set of operating rules, including some 32 rules specified in the order.

The matter proceeded to hearing, and testimony was heard by several witnesses. A Cal-OSHA safety engineer testified that he investigated the accident and cited Parr for violation of L.C. §3664(a) by operating a forklift without securing the load, not tilting the tines and support system backward, and moving the forklift forward without securing the area. The citation was general rather than a serious one. He did not issue a serious citation because he was not persuaded the employer knew or should have known of the violation. He did feel, however, that the employer's failure to observe an unsafe operation in an open area showed a lack of reasonable diligence.

The employee operating the forklift denied prior forklift accidents or warnings. He had been trained in operating the forklift and enforced the forklift safety rules. The employer's chief financial officer admitted that a forklift accident had occurred two years earlier when a cleanup worker rode on the side of the vehicle.

The yard superintendent for the employer testified that he was in the yard observing the employees 90 percent of the time but had been in the office for about 10 or 15 minutes when the injury occurred. He had conducted safety meetings with the forklift operators and other employees, and whenever he saw an infraction, he took the employee aside for correction or write-up if warranted. He had trained the employee who was operating the forklift, gone over the rules, including not moving the forklift with the load in the air, with him and quizzed him about them. The employee operating the forklift had no previous violation or complaints.

In a Findings and Award, the WCJ found the applicant's injury was caused by serious and willful misconduct because the employee operating the forklift was inadequately trained and the forklift rules were not enforced. He awarded increased compensation of $156,649.08 against the employer. The employer sought reconsideration, contending that the findings were not justified by the evidence and applicant had not sustained his burden of proof. Reconsideration was granted for study.

The Board panel indicated that in order to establish serious and willful misconduct under L.C. §4553, there must be proof that the employer, one, knew of the dangerous conditions; two, knew that serious injury to the employee was probable; and, three, deliberately failed to take corrective action. More than gross or culpable negligence, serious and willful misconduct involves conduct of a quasi-criminal nature, intentionally doing something either with knowledge that it is likely to result in serious injury or with reckless and wanton disregard of its possible consequences.

The Board went on and stated that to prove serious and willful misconduct when violation of a safety order is alleged, the following must be shown: One, the specific manner in which the safety order was violated; two, the violation proximately caused the injury. (The specific manner in which it did so must be described); three, the employer or named representative as defined in L.C. §4553 knew of the safety order and the conditions making the safety order applicable and violated, or the condition making the safety order applicable was obvious creating a probability of serious injury; and, four, the failure of the employer representative to correct the condition showed a reckless disregard for possible consequence.

Applying the law to the facts of this case, the panel noted the WCJ had not made the findings required by L.C. §4553.1. The evidence did not, moreover, establish liability under either section. The Cal-OSHA engineer testified that the element of employer knowledge was not present. According to the forklift operator, the employer enforced the forklift safety rules. The yard supervisor established the forklift operator was adequately trained and unsafe practices were corrected when observed.

Although the WCJ wrote that the supervisor should not be considered a credible witness, no explanation for this conclusion was given. The testimony was unrebutted, and no reason to consider it invalid appeared in the record. The forklift operator did in fact violate the safety order in the way he operated the forklift, but there was no evidence the employer knew it, nor evidence that the forklift operator had any prior accidents or that training was inadequate.

The panel, therefore, concluded that applicant failed to meet its burden of proving all the essential elements to establish a case of serious and willful misconduct by the defendants. The evidence in the record fell short of showing that the defendant had knowledge of the unsafe condition that caused the applicant's injury or that the defendant failed to enforce forklift safety rules with reckless and wanton disregard of the consequences.

The decision after reconsideration found that the defendant had not engaged in serious and willful misconduct and ordered that applicant take nothing by reason of his petition for increased benefits under L.C. §§4553 or 4553.1.

5. *Lima v. WCAB(2001)* 66 CCC 1169.

The applicant was employed as a fire captain when he sustained industrial injury to his knees. In January 1997 he was evaluated by an AME who concluded that due to his disability he was a qualified injured worker. Shortly thereafter the applicant's treating physician recommended a disability retirement. When the employer received the medical reports, the applicant was taken off active duty and he was paid L.C. §4850 benefits.

On April 2, 1997 the applicant was placed on disability retirement, at which time his L.C. §4850 benefits terminated. He did not object to the disability retirement. He requested vocational rehabilitation services on April 8, 1997 and he did receive those services.

On March 12, 1998 the applicant filed a L.C. §132(a) petition alleging wrongful retirement without giving him his full L.C. §4850 benefits. He also claimed that at the time he retired the employer knew, but did not tell him that non-retired employees were to be given a new valuable voluntary separation program soon after the applicants retirement.

At first the WCJ found no discrimination under L.C. §132(a). The WCAB granted reconsideration and on remand the WCJ found the applicant entitled to one year of L.C. §4850 benefits and held the employer discriminated against the applicant by retiring him before deciding whether he was entitled to vocational rehabilitation or L.C. §4850 benefits. Again the Appeals Board granted reconsideration and rescinded the WCJ's findings, holding that the applicant retired voluntarily.

The appeals court pointed out that under Government Code §21164 a disability retirement may not occur without the members consent earlier than the date on which L.C. §4850 benefits terminate, or the earlier date on which the members condition is determined to be permanent and stationary. The applicant would be entitled to a full year of L.C. §4850 benefits unless he consented to the retirement. The applicant argued that the evidence does not support a voluntary retirement because he was not told that by not objecting to the retirement proceeding he would lose the remainder of his L.C. §4850 benefits and his potential entitlement to the new voluntary separation benefits. The court rejected the applicant's argument because the applicant was at all times represented by counsel and there is no legal authority for the proposition that an employer must notify an employee of all legal consequences of a decision to retire him. In fact, the record supports that the applicant consented to the retirement. This case can be distinguished from *City of Martinez V. WCAB (Bonito)* (2000) 65 CCC 1368, because in that case the applicant did not consent to the retirement. Whereas, here, the applicant told a member of the retirement board that he had his own business now and that everything would be alright.

The court held there was no violation of L.C. §132(a) because Government Code §21164 allows termination of L.C. §4850 benefits if the worker consents to retirement. Further, the applicant was retired prior to the time that the new voluntary retirement benefit package was first offered. The Appeals Court found that the employer acted properly pursuant to L.C. §4850 and Government Code §21156 (which requires retirement for incapacity which is a legitimate business necessity).

6. *Melton v. Industrial Indemnity Co.* (2001) (Court of Appeal) 66 CCC 41, Depublished, not citable.

In a 101-page opinion, the Court of Appeal affirmed a trial court judgment finding the employer's workers' compensation insurer liable for insurance bad faith. The carrier refused to indemnify an employer for L.C. §132a liability after the employer fired an employee who expressed an intention to file a workers' compensation claim. The court concluded the employer's liability was covered under the workers' compensation portion of the policy notwithstanding the fact that the firing was an intentional act.

The injured worker fell off a ladder and missed several weeks of work. By the time the worker was able to return to his job the employer had replaced him with someone else. Several weeks before hearing on the regular issues the employee filed a complaint pursuant to section 132a. The carrier's position with respect to 132a claims was that an employer's liability was not covered by the standard workers' compensation policy, but that the carrier customarily provided the employer with a courtesy defense of the 132a claims. The carrier's internal manual directed the claims department to send the employer a standardized 132a letter, which set forth the company's no-coverage position, but offered "as a service" to pay for an attorney selected by the employer. In the current case, however, the carrier neglected to send that letter. The issue of whether the employer was made aware of the carrier's position some other way became a significant factual issue in the case.

The carrier referred the normal issues to defense counsel and, soon after referral, the underlying case settled by way of compromise and release for $4,200.00. The 132a claim was not concurrently resolved. The opinion contains an extensive summary of the subsequent facts, or in many respects, what appears to be a comedy of errors. Stated most simply, the carrier closed its file after the resolution of the main issues, only to reopen it after the attorney for the injured worker inquired about taking the deposition of the employer. There was a significant factual dispute concerning whether the carrier then notified the employer a courtesy defense would be provided without agreeing to indemnify the 132a claim. There was significant confusion on behalf of the attorney retained to represent the employer, as he often appeared in court and in pleadings as attorney-of-record for the carrier. The injured workers' damages under 132a continued to mount because he was off work for an extended period of time and his lost wages continued to accrue. The case ultimately resolved by settlement, funded by a loan the employer took against his house.

Although the extensive recitation of facts reflected tremendous confusion and imprecision on the part of the carrier and attorneys involved, the truly significant aspect of the opinion is the court's conclusion that an employer's section 132a liability comes within a standard insurance policy's general coverage for "compensation and other benefits required of the insured by the workers'

compensation law." The court further held that coverage for the liability is not precluded by the "accident" limitation in the insuring agreements, nor by the public policy expressed in sections 533 of the Insurance Code and 1668 of the Civil Code against insurance for willful acts.

The court noted that compensation is statutorily defined by Labor Code section 3207 as "compensation under Division 4 of the Labor Code," and the carrier argued that Coverage A of the policy applied only to compensation and other benefits required of an insured by that division. The carrier asserted section 132a does not fall within the coverage because it is in Division 1 of the code and because the remedy is in the nature of a penalty rather than compensation. The Court noted the language of the policy covers "all compensation and other benefits required of the insured by the workers' compensation law," and construed the more reasonable interpretation as "all compensation and other benefits recoverable in a workers' compensation proceeding." The court further noted that the express language of section 132a provides for increased compensation, and that the award under 132a serves a remedial as well as a deterrent purpose and is therefore compensatory and not merely punitive.

The carrier asserted the discharge of an employee in violation of section 132a is necessarily an intentional act and therefore is not injury caused by "accident" occurring during the policy period. There was no real dispute that the employer's discharge of the injured worker was a deliberate act, but the parties disagreed on the significance, if any, of the employer's state of mind at the time. The carrier maintained it was enough that the employer acted intentionally and it was immaterial whether or not he intended to harm the employee. The employer, on the other hand, asserted the policy precluded coverage only if he had acted with a preconceived design to inflict injury (which he denied). The court noted that in the case of a 132a violation the act and the harm are essentially the same thing. The holding that the discriminatory act and resulting harm were intentional, however, did not resolve the issue because of ambiguity in the insuring agreement. The court noted the distinction between California and the majority of jurisdictions; in those other jurisdictions, virtually all intentionally tortious acts committed by an employer against an employee in the course of employment are excluded from the workers' compensation systems, and the employees are then free to pursue civil actions. In California, because of the workers' compensation exclusivity statute, any injury is covered by the act without reference to accident or intentional tort. For example, an employee's injury which results from the employer's serious and willful misconduct has a statutory remedy within the workers' compensation system, and therefore the Legislature has evidenced its intent to include at least some portion of what would typically be classified as intentional torts within the workers' compensation system.

After a lengthy analysis, the court concluded the accident limitation in the policy is ambiguous because it fails to clearly distinguish between what it is arguably meant to exclude (an employer's 132a liability) and what it purports to exclude but does

not (an employer's ordinary liability for non-accidental workplace injuries). Because the drafter of the insurance policy created the ambiguity, it was resolved against the carrier and in favor of coverage.

7. *Roebbelen Construction v. Workers' Compensation Appeals Board (Fauver)* (2001) 66 CCC 235.

Applicant worked as a journeyman carpenter, leadman and foreman for over 20 years. Between 1989 and April, 1997, he was employed approximately 90 percent of the time as a carpenter for Roebbelen. He suffered two industrial injuries while working for Roebbelen. He was reprimanded for his delay in reporting the first industrial injury. The second industrial injury resulted in his being placed on light duty following surgery to his finger. He quit his job in early March 1997, saying he was not paid enough for the short time he was working. He was working fewer hours on the job, leaving at noon three days a week in order to pick up his children and make physical therapy appointments. The physical therapist was 80 miles away. With the employer's help, he found a physical therapist nearer the work site two days before his second surgery, but did not want to change for two days.

Following the second surgery, the applicant was returned to work at full duties in April 1997. The applicant called Milhous, the project supervisor, and others about jobs at Roebbelen. They indicated they anticipated openings in the future and encouraged him to keep calling. He spoke with Milhous again in August 1997 about a job at the new Broadstone Elementary School, where Milhous would serve as superintendent. Milhous told the applicant construction had not started. Milhous suggested that the applicant register at the union hall since there was a shortage of qualified carpenters in the area. The applicant did not do so. Milhous then met with Terrence Street, the president of Roebbelen Construction, about hiring a foreman for the Broadstone project. Street opposed giving applicant the job because the applicant was likely to follow Milhous when he left to work at another company, and, although the applicant could handle the duties of a foreman, he could not step into the superintendent position, and Street considered the applicant a safety risk due to his failure to report on-the-job injuries which was contrary to the company rules. Milhous told the applicant that he would like to hire him, but there had been a management decision not to hire him. He told the applicant that Street considered him a safety risk and said that in a field of ten carpenters, he would be the one to be injured.

The applicant explained that his historical practice in working with Roebbelen was to call Milhous when he wanted to work and Milhous would hire him on a job. He later clarified that the practice happened only one time when he was laid off and went to work for another company. Between April 1997 and February 1998, the applicant did not apply for work with any building contractor other than Roebbelen. During that time he was self-employed, selling memberships in Nationwide Auto Club, Excel Long Distance Service and a weight loss program. He also obtained a handyman's license. During February, 1998 the applicant

worked for Tuttle Interiors, another building contractor, for nine days. A month later he started work as a carpenter foreman for JB Company, where he is today.

The applicant petitioned the Workers' Compensation Appeals Board for benefits under L. C. §132a. In his petition he alleged that Roebbelen's refusal to return him to work was in retaliation for his having made this claim or otherwise exercised his rights under the workers' compensation laws.

The WCJ found that the employer discriminated against the applicant for an industrial injury by failing to reinstate him when he was released by his physician to return to his full and regular duties and on the ground that the employer is in violation of L. C. §132a. The WCJ also found that the applicant attempted to mitigate his damages. The WCJ did not specifically address the argument that the applicant was not employed by Roebbelen at the time the company refused to rehire him.

The Petition for Reconsideration was denied even though the defendant argued that the applicant was not an employee at the time of the alleged discrimination.

The Court indicated that L. C. §132a applies to acts by employers against employees. The preliminary jurisdictional question whether a worker is an employee arises in many contexts in workers' compensation law. A worker proves a violation of L. C. §132a by showing that as a result of an industrial injury, the employer engaged in conduct detrimental to the worker. If the worker makes this showing, the burden shifts to the employer to show that its conduct was necessitated by the realities of doing business.

The Court pointed out that the uncontradicted evidence shows the applicant quit his job with Roebbelen after the company placed him on light duty. The applicant told Milhous he could not continue working due to the need to go to physical therapy, the distance, and his children's needs. The applicant quit despite Roebbelen's efforts to lighten his travel burden by locating a physical therapist near the work site. The applicant did not perform services for Roebbelen after that date. Accordingly, the Court of Appeal stated there is no presumption the applicant was an employee at the time Roebbelen refused to rehire him. Moreover, the suggestion that there was an understanding or historical practice between the applicant and Milhous, that the company would rehire the applicant when he left and wanted to return to work, is not supported by the evidence. The applicant conceded the practice happened only once when Roebbelen laid him off, and he went to work for another construction company. Here, the applicant was not laid off, he quit.

Citing the *City of Anaheim v. Workers' Compensation Appeals Board (Brazz)*, (1981), 124 Cal. App. 3rd 614, 46 C.C.C. 1264. The Court found that L. C. §132a requires that an employer-employee relationship at the time of the discharge, threat of discharge or other discriminatory act.

The Workers' Compensation Appeals Board, in upholding the judge, relied on the case of *Barns v. Workers' Compensation Appeals Board*, (1989) 216 Cal. App. 3rd 524, 54 C.C.C. 433. The Board indicated that they relied on *Barns* and tried to distinguish the *City of Anaheim* case.

The Court, in *Barns*, distinguished the *City of Anaheim* case by stating that the critical distinction between *City of Anaheim* and *Barns* is that the employment relationship had been unequivocally and lawfully terminated before the alleged discriminatory action. In the *Barns* case the purported termination itself was discriminatory. The Court, in *Barns*, indicated it cannot provide a basis for immunizing the employer's later discriminatory conduct.

The Court stated in this case, the applicant unequivocally and lawfully quit his job with Roebbelen. There was no allegation the applicant was terminated or discriminated against at that time. Absent facts which establish an employment relationship or discriminatory termination, L. C. §132a is inapplicable to sanction Roebbelen's allegedly discriminatorily failure to rehire. We, therefore, conclude that the Board exceeded its power in denying defendant's petition for reconsideration.

The award of 132a benefits was annulled.

XXVIII Penalties, Sanctions & Contempt

1. *Baker v. Lucky Stores* (2001) 29 CWCR 286 (Board Panel Decision).

Applicant sustained a specific injury on February 10, 1998 and a cumulative injury while employed by Lucky Stores. It was found that applicant's injury caused disability of 38 percent. The RU determined that applicant was entitled to vocational rehabilitation services and because defendant had not provided timely services, continuing VRMA was awarded at the temporary disability rate until defendant arranged a meeting for applicant with a QRR. Defendant allowed the RU order to become final but did not comply with it until seven months later when it agreed to a QRR and started paying VRMA.

Applicant petitioned for a 10 percent increase in benefits pursuant to L.C. §5814, the delay in complying with the RU order, and for not automatically adding 10 percent to the delayed payments of VRMA. The applicant also sought an order that the delayed VRMA be increased by the automatic 10 percent required by L. C. §4650(d).

Following a hearing, the workers' compensation judge awarded a L.C. §5814 penalty for unreasonable delay in commencing VRMA payments and selecting a QRR to provide VR services. The WCJ also ordered defendant to increase each of the late VRMA payments by 10 percent pursuant to L.C. §4650(d).

Defendants petitioned for reconsideration, contending that L.C. §4650(d) is applicable only to permanent disability and temporary disability payments and does not apply to VRMA; applying L.C. §4650(d), L.C. §5814, and AD Rule §10125.1 resulted in three penalties for the same act; and, three, compelling the employer to pay VRMA at the TD rate and outside the cap alone was powerful incentive to pay VRMA timely.

The WCJ in her report and recommendation on reconsideration emphasized that she had not decided that all VRMA payments are subject to L.C. §4650(d) but only the narrow issue that VRMA payments at the TD rate are subject to L.C. §4650(d).

Because L.C. §4650(d) does not expressly include or exclude VRMA, it was necessary to ascertain the intent of the legislature so as to effectuate the purpose of the law. L.C. §3202 requires liberal interpretation of L.C. §4650(d) with the purpose of extending its benefits for the protection of injured workers. The purpose of L.C. §4650(d) is to encourage claims administrators to keep weekly benefits current. Application of L.C. §4650(d) to VRMA that is payable at TD rate is consistent with the purpose of VR and harmonizes the statute and rules to give effect to each in light of the Workers' Compensation system as a whole.

In *State Compensation Insurance Fund v. WCAB (Monroy)* (1999) 64 CCC 1324, the WCJ noted, the board panel applied it to VRMA that was not payable at the TD rate because it was unnecessary to go that far in this case.

The WCJ rejected defendant's claim that applying L.C. §4650(d) in addition to L.C. §5814 and AD Rule §10125.1 (which provides that VRMA during any delay caused by the employer shall be paid at the TD rate) results in three penalties for the same act, saying that the increase did not arise out of the same act. The order to pay at the TD rate was for the delay before the RU order. Therefore, defendant delayed compliance with the order for another seven months.

Increases under L.C. §4650(d) and L.C. §5814 are independent, not duplicative. Here, moreover, the L.C. §4650(d) increase was for delay in the weekly payments, but the L.C. §5814 increase was for unreasonably delaying in compliance with the RU order. L.C. §4650(d) increases apply without regard to the reasonableness of the delay, only to the payments' delay. The judge added that while defendants indicate that compelling defendant to pay VRMA at the TD rate and outside the cap is already a powerful incentive to promptly administer benefits, defendants still failed to pay applicant despite the powerful incentive.

A WCAB panel adopted the reasoning of the WCJ and denied reconsideration.

2. *Businger v. Workers' Compensation Appeals Board (2001)* 66 CCC 157.

The parties settled all claims by way of a compromise and release for $100,000.00. From the proceeds, $12,000.00 was to be paid as an attorney fee and another $6,314.57 was to be deducted to pay a lien from Stanford Voluntary Plan, a private disability provider. The C&R specified that payments were to be made within 25 days after issuance of the order approving compromise and release and the interest was waived if payments were made in a timely fashion. An order approving compromise and release issued and the applicant received her check in a timely fashion. Thirty days after the order approving compromise and release, applicant's attorney had not received his check. As a result, applicant's attorney filed a petition for penalties under L.C. §5814. Three days later the defendant paid the attorney's fee, but failed to pay the interest. Applicant's attorney filed a second petition for penalties for defendant's failure to pay the interest. The defendant paid the interest eight days later.

At trial the testimony established that the claims adjuster approved payment to the applicant, the applicant's attorney and the disability insurance plan, then sent the checks to the defendant who needed to co-sign them. The three checks were sent by three separate cover letters. Only one cover letter was signed, although the three checks were signed. The adjuster for the defendant was apparently a stickler for detail and refused to sign the two checks that were attached to the unsigned cover letters. This was the first time this had happened. The adjuster was informed the three checks had been sent back, but she never received them. The adjuster called the voluntary disability plan and was told that they had not received their check. She first learned about the problems with the applicant's attorney's check when the petition for penalty was filed. She immediately called and stopped payment on the check. She then sent another check to the applicant's attorney. She did not think about the interest check until her attorney called and said it had not been paid. She then issued a check for the interest.

The WCJ found the testimony of the adjuster credible and ruled there was no unreasonable delay in paying benefits. Applicant filed a petition for reconsideration. The WCJ, in his report and recommendation on petition for reconsideration, stated the payments were clearly delayed, with the burden shifting to the defendant to show the delay was reasonable. Relying on State Compensation Insurance Fund v. WCAB (Stuart) (1998) 63 CCC 916, the WCJ noted that reasonableness may be established by showing that the delay was inadvertent and that in this case the delays were clearly inadvertent. Regarding the late payment of interest, the WCJ concluded, based on the testimony of the claims adjuster, that failure to pay interest was an oversight and a penalty was inappropriate under Stuart.

The Board denied reconsideration and pointed out that applicant's attorney did not make a demand for payment when the checks were not in receipt, but instead filed petitions for penalties before giving defendants an opportunity to discover and correct it's inadvertent error. The Board agreed with the WCJ that there was no basis for penalty, as there was no unreasonable delay as the failure to pay was

inadvertence in accordance with Stuart. A writ of review was filed by applicant's attorney which was denied.

3. *California Highway Patrol v. WCAB (Erebia*) (2001) 66 CCC 687.

The applicant was awarded $224.00 per week for life, future medical treatment, and reimbursement for out of pocket medical expenses. The award further provided for $107,000 credit for funds received from a third party. The defendant was not required to make any disability payments or medical payments until the third-party credit was exhausted. On June 14, 1997 the applicant mailed information to State Compensation Insurance Fund, CHP's adjusting agency, showing that the third-party payments had been exhausted. Two days later State Fund received the notice. Six weeks later State Fund resumed permanent disability benefits and made a retroactive payment of permanent disability benefits. The retroactive payment did not include interest. The applicant filed a notice he was seeking penalties under L.C. §5814 for unreasonable delay in permanent disability, for failure to include accrued interest when making the retro-active disability payment, and for delay in paying for medical treatment.
The WCJ found a delay of six weeks in permanent disability and that the CHP presented no evidence as to why a delay of six weeks after the exhaustion of its credit rights occurred. The WCJ found the delay was unreasonable and assessed a 10% penalty on permanent disability under L.C. §5814. The WCJ also made a separate finding that the CHP failed to pay accrued interest on the late payment of permanent disability and that the failure to pay interest was unreasonable. Based on this finding, the WCJ assessed an additional 10% penalty on permanent disability under L.C. §5814. The WCJ also made a third finding that the CHP failed to timely pay medical benefits and this delay was unreasonable and he assessed a 10% on all medical benefits under L.C. §5814.

A Petition for Reconsideration was filed by the defendant asserting several arguments, including the argument that the failure to pay interest on the retroactive payment was improper because the failure to act timely in payment of permanent disability and interest was a single act and not separate and distinct acts. The WCAB denied reconsideration. Under L.C. §5814 the WCAB must impose a 10% penalty if payment of compensation has been unreasonably delayed or refused. Because the term "compensation" has been construed to include interest, this statute requires the WCAB to impose a 10% for delayed or refused interest payments as well as delayed or refused principal payments. The 10% penalty for a delayed or refused interest payment is calculated based on the total amount of the benefit to which the interest attaches. This is because interest is considered to be part and parcel of the original compensation award and, therefore, within the same class of benefits. The WCJ made findings that the CHP unreasonably delayed making PD payments and unreasonably failed to include interest with the retroactive payment of PD. The defendant did not challenge these findings nor does CHP disagree that each of these actions may independently support a L.C. §5814 penalty. The defendant contends, however, that the WCAB had no

authority to award two penalties under L.C. §5814 for a single payment that was late and failed to include interest.

Although the language of L.C. §5814 does not expressly prohibit multiple penalties, the Supreme Court has construed the statute to limit the WCAB's authority to impose two penalties at one time. Relying on the legislative history and the policies underlying the statutory penalty, the Christian court held that L.C. §5814 permits multiple penalties for delay or non-payments only when the unreasonable delay or refusal of those benefits is attributable to separate and distinct acts by the defendant. Separate and distinct acts occur if (1) multiple penalties involve separate classes of benefits; or (2) the delay or refusal occurs after the same conduct had already been found by the Board to be unreasonable and a prior penalty imposed, or some analogous, legally significant event such as a stipulation of liability by the carrier had intervened between the first act for which a penalty was imposed and the second. The Court concluded that under the two prong test in Christian the multiple penalties based on a single payment were likewise improper in this case. First, the CHP had not been previously been penalized for the late installment payments, or for failure to pay interest on those payments. Second, the conduct for which CHP was penalized twice concerns a single payment reflecting the same class of benefits.

Under L.C. §5800, awards of the WCAB for compensation shall carry interest at the same rate as judgements in civil actions. With respect to installment payments, interest shall run from the date when each of the amounts becomes due and payable. When owed, interest should always be commuted and paid with the payment of the principal award, absent special circumstances. Thus, under L.C. §5800, the underlying compensation payment and accrued interest are integrated components of the same class of benefits. Because the interest and installment payments relate to the same class of benefits and there was no prior penalty, the imposition of two 10% penalties for a single act of paying the installments late and without interest is prohibited. The portion of the WCAB's award denying reconsideration relevant to the assessment of a 10% penalty for failure to pay interest was annulled. The remaining portions of the order were affirmed. The matter was remanded to the WCAB.

4. *County of Los Angeles v. Workers' Compensation Appeals Board (Dulan)* (2001) 66 CCC 380(writ denied).

Applicant, a firefighter with a 1992 industrial injury, resolved his case in chief with Stipulations with Request for Award. He also filed a petition claiming defendant violated L. C. §132(a) by terminating him. In June of 1999 the WCJ found defendant violated L. C. §132(a) and ordered defendant to reimburse applicant for lost wages and benefits and to reinstate applicant to his former firefighter position.

The L.C. §132(a) finding was the subject of a previous Petition for Reconsideration and Writ of Review where the Court of Appeal denied defendant's petition for

writ of review. The Court of Appeal denied writ of review on January 11, 2000. The Supreme Court denied review on March 1, 2000.

Applicant subsequently sought a L. C. §5814 penalty related to the L. C. §132(a) Finding and Award. The WCJ held a conference and set a hearing date, but on the scheduled hearing date of November 10, 2000, the matter was submitted without testimony.

In a supplemental Findings and Award, the WCJ found four separate and distinct acts of unreasonable delay by defendant and awarded four L. C. §5814 penalties. The WCJ found defendant unreasonably delayed (1) paying lost wages and benefits pursuant to the prior 6-14-99 Findings and Award; (2) providing an accounting of benefits due applicant; (3) paying benefits by failing to follow applicant's signed waiver of a redeposit requirement related to his retirement account; and (4) paying attorney fees pursuant to the prior Findings and Award.

Defendant sought reconsideration of the supplemental Findings and Award disputing the four L. C. §5814 penalty awards and contending the WCJ should have held a hearing and heard testimony before issuing a supplemental Findings and Award and that the failure to do so violated defendant's due process rights. Defendant further contended the WCJ had a duty to develop the record on whether the Los Angeles County Employees Retirement Association had accepted applicant's waiver of retirement rights, and whether LACERA was a separate entity from defendant County of Los Angeles, so that LACERA's failure to accept a waiver was not attributable to the defendant, and on whether deductions from applicant's retirement fund exceeded the sum due to applicant under the L. C. §132(a) award.

Defendant also contended L. C. §5814 did not apply to delays in providing an accounting and that its payment of attorney fees was not unreasonably delayed when there was no fund from which to deduct a fee.

The WCJ recommended, in his Report and Recommendation on Reconsideration, that it be denied as to all penalty awards. On the LACERA issue, the WCJ noted that applicant signed a waiver of a requirement for him to redeposit funds into his retirement account with LACERA. Defendant claimed it could not pay applicant back wages and benefits because applicant owed more money to his retirement account than was due under L. C. §132(a) award. The WCJ found this issue of potential credit was not raised in defendant's first petition for reconsideration of July 9, 1999, and was raised for the first time at the 5-20-2000 conference. The WCJ found defendant's claim for potential credit did not change the 6-14-99 Findings and Award. The WCJ stated: "Defendant should have paid the applicant his lost wages pursuant to the Findings and Award, and then have the applicant deal with LACERA separately regarding his retirement contributions."

The WCJ also discussed defendant's contention that the WCJ should have held a hearing related to the LACERA and child support lien issues before issuing a supplemental Findings and Award. The WCJ found that the child support lien was not at issue at the July 10, 2000, hearing on penalties. The WCJ stated that the WCAB had no duty to hold a hearing in these circumstances because applicant and defendant had agreed at the time of the scheduled hearing date of July 10, 2000, to submit the case on the present record after filing briefs and without additional testimony. Moreover, the LACERA retirement account and family support lien were not issues at that hearing, and the WCJ issued a supplemental Findings and Award after the case was submitted. The WCJ found no due process violation for failure to hold a hearing. The WCAB denied reconsideration and adopted and incorporated the WCJ's reconsideration report without further comment.

The writ was denied.

5. *County of San Luis Obispo v. WCAB (Barnes)* (2001) 66 CCC 1261.

The applicant was injured in 1973 while working for the County. In 1981, he received an award of 100% PD and further medical treatment. In 1991, he sought multiple penalties for various alleged delays by defendant in providing medical treatment in the prior ten years. However, the WCAB awarded a single 5814 penalty on all medical benefits (past, present and future). Following this penalty award, the parties informally agreed that a penalty check would issue at the end of each quarter, after the medical expenses paid in the previous quarter had been calculated. But, the parties did not agree to a timetable for paying the quarterly penalties. In 1997, Barnes filed another petition alleging multiple penalties, including a delay in paying the previously awarded penalty for the quarter ending April 30, 1995, in the amount of $97.87. Although that $97.87check issued on May 11, 1995, it was not sent to Barnes until July 15, 1995. Ultimately, the WCAB awarded Barnes one L. C. §5814 penalty for defendant's delay in making the $97.87 payment. Defendant filed a petition for writ of review. At the time of its petition, defendant had paid medical expenses exceeding $650,000. In its petition, defendant contended that a penalty in excess of $65,000 for an inadvertent delay in paying a $97.87 penalty constituted harsh and unfair treatment not intended by the Workers' Compensation Act. Defendant also argued, among other things, that the penalty would be an excessive fine in violation of the Eighth Amendment of the U.S. Constitution and Article I, §17, of the California Constitution.

The Court of Appeal found no unreasonable delay and reversed the WCAB's penalty award. In so finding, the Court of Appeal noted the language, originally set forth in *Gallamore* and reiterated in subsequent Supreme Court decisions, that in penalty cases the WCAB "should proceed with a view toward achieving a fair balance between the right of the employee to prompt payment of compensation benefits, and the avoidance of imposition upon the employer or carrier of harsh and

unreasonable penalties." The Court of Appeal also reviewed the "totality of circumstances." Among other things, the Court of Appeal noted:

(1) that "uncontradicted evidence in the record gives rise to the inference that the delay was inadvertent" and that the actions of the employer were not those of an employer "bent on delaying payment";

(2) that, at the time the penalty check was issued, defendant had been paying Barnes' medical expenses for more than 25 years and had been making quarterly penalty payments without complaint from him for approximately four years;

(3) that when defendant became aware that the check had not been sent to Barnes, it took "prompt corrective action" and mailed the check to him;

(4) that the parties' 1991 agreement did not contain any timetable for payment, that the record indicated the penalty checks were mailed anywhere from 4 to 5 weeks after each quarter had ended, and that, by analogy to *Avalon Bay Foods v. WCAB (Moore*) (1998) 63 CCC 902 and to Labor Code §4603.2, defendant reasonably had 60 days within which to issue the penalty check;

(5) that there was "no history of improper processing of benefit payments or evidence of institutional neglect," but rather "a solitary instance of human error, which was quickly corrected upon discovery";

(6) that Barnes contributed to the delay by failing to notify his employer that the check had not arrived within the usual 4 to 5 weeks;

(7) that the size of the late payment in relation to the amount of the potential penalty is relevant because the court must examine the entire record for "fairness, reasonableness, and proportionality in the overall scheme of the workers' compensation law and the purposes sought to be accomplished by that law" and, here, "it cannot be disputed that the potential penalty is grossly disproportionate to the amount delayed";

(8) that the delay "did not involve furnishing or paying for medical treatment; therefore, imposing such a grossly disproportionate penalty for an inadvertent delay would not serve the purposes of L. C. §5814"; and

(9) that "imposition of a penalty here would upset the balance of fairness and result in a windfall to the applicant out of proportion to the employer's conduct and impose upon the [defendant] a harsh and unreasonable penalty."

For the above enumerated reasons the Court of Appeal found that the defendant's delay was not unreasonable. The Court did not reach the constitutional issues raised by the defendant inasmuch as it found no delay in the first instance.

6. *Flowers v. WCAB* (2001) 66 CCC 753 (writ denied).

Applicant compromised and released his case by $40,000. An order approving compromise and release issued for $40,000 less a reasonable attorney fee of $6,000. Defendants made payment of the compromise and release on the 28th day after the order issued. The parties then entered into a stipulation that defendants agreed to pay applicant $6,000 in full and final settlement of all penalties for the late payment of the compromise and release, and the attorney requested a 20 percent fee. The WCJ ordered the defendants to pay, according to the stipulation, the $6,000 payable to the applicant, less 15 percent payable to Applicant's attorney as attorney's fees.

Applicant then filed a declaration of readiness to proceed, stating that the defendants had unreasonably delayed the payment of the settlement of the penalty issue. The WCJ found that defendant had unreasonably delayed the payment of the penalty settlement and interest. The WCJ issued an award of 10 percent penalty pursuant to L. C. §5814 against the C & R amount.

The WCAB granted reconsideration and rescinded the WCJ's penalty awards, reducing the multiple penalty assessed to one Labor Code §5814 penalty for defendants' single course of conduct in the late payment of the penalty settlement and interest settlement. The WCAB indicated that they were persuaded that the late payment of interest and the late payment of the settlement was part of a single course of conduct rather than two separate, distinct acts of unreasonable delay. Applicant filed a petition for writ of review, which was denied.

7. *Gangwish v. WCAB* (2001) 66 CCC 584.

The applicant admittedly injured both shoulders, knees, his back and skin, and sustained loss of hearing bilaterally with tinnitus while employed as a firefighter/inspector for the City from April 13, 1968 to March 1, 1999. In addition, the applicant injured his right knee on February 1, 1995, the left shoulder on July 12, 1996, the right calf on March 27, 1997, the back and right shoulder on July 10, 1998, and the back on August 31, 1999.

The applicant became represented by an attorney. On October 2, 1998, he demanded payment of PD plus 10% pursuant to L. C. §4650(d). His claim was based on his hearing loss described in Dr. Freed's report. The defendant responded by letter that the date of injury for the hearing loss was May 17, 1984, and L. C. §4650(d) only applied to injuries on or after January 1, 1990. The defendant also indicated that the applicant would be re-evaluated by Dr. Freed to address his continuous trauma claim. The applicant responded by letter that Dr. Freed stated the hearing loss occurred as a result of a continuous trauma. The applicant again demanded payment of PD and a L. C. §4650(d) penalty, and also requested multiple penalties under L. C. §5814. On October 28, 1998, the City issued a PD

payment of $2,730 based on the March 2, 1990 report of Dr. Freed. The payment included accrued PD but not a L. C. § 4650(d) increase.

Dr. Freed re-evaluated the applicant on November 17, 1998, and indicated the hearing loss began in the mid-seventies and worsened over the years due to noise from sirens, air horns, traffic and heavy equipment. He found no specific hearing injury in May of 1984. On January 13, 1999, the City issued another PD payment for $2,004.25 covering the period from November 17, 1998 to January 16, 1999.

The applicant filed a petition for penalties against permanent disability. The applicant alleged the City was obligated to begin PD payments within 14 days of Dr. Freed's report of March 2, 1998, and the failure to do so for the reason given by the defendants required a 10% penalty under L. C. §5814. In addition, when payment of PD was finally made months later, the City did not include the 10% increase under L. C. §4650(d) which unreasonably was delayed and justifies a second 10% penalty L. C. §5814.

The parties then proceeded to trial on the issues of PD and multiple penalties. The WCJ determined the applicant was permanently and totally disabled. In regards to the penalty, the WCJ awarded a single 10% increase under L. C. §5814 because the City failed to timely advance PD despite compensable medical evidence. The City has not challenged this finding.

Applicant filed a petition for reconsideration with the WCAB. Applicant agreed with the WCJ that the City unreasonably failed to pay PD for seven months after receiving Dr. Freed's report and penalty was justified. However, the applicant alleged that L. C. §4650(d) also applied, and the City's failure to pay the increase should have resulted in another L. C. §5814 penalty. In his Report on Reconsideration, the WCJ responded that L. C. §4650(d) does not apply where there was no periodic payment of TD or PD, as indicated by L. C. §4650(b). Since L. C. §4650(d) was inapplicable, there was unreasonable refusal or delay in paying the 10% increase. The WCAB denied reconsideration. However, the WCAB rejected the WCJ's reasons. Instead, the WCAB concluded that L. C. §4650(d) is not triggered because, under the statute no increase shall apply to any payments due prior or within 14 days after the date the claim was submitted to the employer under L. C. §5401.

The WCAB reasoned that in order for the 10% increase to apply, the claim form had to be filed before the PD payment on October 28, 1998. Because applicant did not offer the hearing loss claim form into evidence, this showing was not made. Therefore, no additional L. C. §5814 penalty was owed.

The Court of Appeal found that L. C. §4650(b) expressly provides that PD payments begin only within 14 days after the last payment of TD. The logical implication is that the payment of TD must occur before a PD payment is owed

under L. C. §4650(b) and consequently before any increase for late PD is due under L. C. §4650(d). This result, however, should be harmonized with the purpose of the statute as a whole, and with workers' compensation law.

The legislative history indicates the purpose of enacting changes to L. C. §4650 was to promote prompt payment of benefits and certainty of timing. This part of the legislative change in L. C. §4650(b) omitted the option of paying PD once permanent and stationary status is achieved. This does not mean, necessarily, the legislature intended that TD precede PD before prompt payment of PD is required. The change is consistent with an uninterrupted flow of time benefits during the transition from TD to PD by eliminating the other option of when a payment is due. Furthermore, determining the permanent and stationary date is often uncertain. It is not uncommon for medical opinions regarding an injured worker's status to vary.

In addition, former L. C. §4651 provided that payments of TD or PD were to be made not less frequently than twice each month, except by order of the WCAB. This chronology of benefits was essentially recodified in L. C. §4650(c) which states payment of temporary disability or permanent disability indemnity subsequent to the first payment shall be made as due every two weeks on the date designated with the first payment. L. C. §4650(c) is further substantiation of the legislature's purpose, since it provides for payment of continuing TD or PD at regular intervals.

The language of L. C. §4650(c) provides that subsequent PD payments every two weeks begin directly after the first payment of PD rather than after the last payment of TD as in L. C. §4650(b). It follows that subsequent PD payments are contingent upon a payment of PD and not TD, and L. C. §4650(c) is applicable, even if TD is not paid.

Late subsequent PD payments under L. C. §4650(c) are, therefore, subject to the increased compensation provisions of L. C. §4650(d) which expressly applies to all payments under L. C. §4650.

Applying L. C. §4650 to subsequent PD payments but not to the initial payment of PD when TD is not paid is consistent and in harmony with statutory language and goals. When TD is not involved, payment of PD is typically owed following the date permanent and stationary status is achieved.

As stated previously, the permanent and stationary date is often uncertain. However, once the initial payment of PD is made, the timing of subsequent PD becomes certain when payment is required every two weeks thereafter under L. C. §4650(c). Therefore, the WCAB must determine the amount of subsequent PD in the October 26, 1999, payment of $2,730, and then apply L. C. §§4650(c) and (d) to that amount.

In addition, there was another payment of PD on January 13, 1999, for $2,004.25. Although the record indicates the period covered was from November 17, 1998, through January 16, 1999, and the payment followed Dr. Freed's November 17, 1998 report, it is not entirely clear this was subsequent PD paid pursuant to the hearing loss. This should also be addressed by the WCAB.

The WCAB rejected the WCJ's reasons and introduced its own rationale for the decision that there was no evidence the claim form preceded the payment of PD by 14 days as required by L. C. §4650(d). Applicant claims he was denied an opportunity for rebuttal, which violated due process, and the applicant is correct. The Court, citing *Rucker vs. WCAB*, (2000) 82 Cal App 4th 151, stated the Court of Appeal, in that case, found due process was violated when the WCJ's amended decision was based on a completely different theory than presented by the the parties, without affording chance for rebuttal. Here applicant was provided even less opportunity, since the WCAB, rather than the WCJ, established the new grounds.

The WCAB found there was no showing the claim form had been submitted to the City prior to or within 14 days under L. C. §4650 because the claim form had not been offered into evidence. The reasoning is not supported by the record and further demonstrates why an opportunity for rebuttal is necessary. In *Rucker*, a letter written by the petitioner to the WCJ which concerned issues for trial was contained in the WCAB file and was considered part of the record by the Court of Appeal. In this case the claim form is also part of the WCAB's file. In addition, the claim form is an official form under L. C. §5401, which triggered certain liabilities and obligations, including those under L. C. §4650. The claim form is clearly part of the record.

Furthermore, the claim form was part of the jurisdictional and procedural documents date-stamped as received by the WCAB on October 6, 1998, four days after mailing. There is no reason to find that the defendant did not receive the claim form at or about the same time, which, along with the mailing, was more than 14 days before the October 28, 1998, payment of PD occurred. Defendant testified the hearing loss application for adjudication had been received when PD was paid, and the City responded on October 13, 1998, to applicant's other letter. Thus, the uncontroverted record establishes the claim form requirements of L. C. §§4650(d) and 5401(c) were satisfied. Therefore, it is unnecessary for to decide whether the City should have provided a claim form earlier or is estopped.

It is well settled that an unreasonable delay or refusal required for a 10% increase in compensation under L. C. §5814 occurs when there is no genuine doubt benefits are owed from a medical or legal standpoint. The City had reasonable doubt from a legal standpoint in regards to L. C. §4650, since under the statutory language the initial payment of PD is not subject to L. C. §§4650(b) and (d) when TD is not paid. In addition that subsequent PD payments are subject to L. C. §4650 appears to be of first impression.

The decision of the WCAB in regards to L. C. §4650 was annulled and the matter remanded for further proceedings consistent with the decision.

8. *Garcia v. The Vons Company, Inc*, (2001) 66 CCC 469 (Board En Banc).

The Board on its own motion, removed this case to itself under L.C. §5310. The removal was ordered so the Board could consider whether the filing of an untimely petition for reconsideration by Valley Subrogation & Associates, on behalf of lien claimant, La Mirada Psychiatric Group, was sanctionable conduct resulting from bad faith actions or tactics that are frivolous or solely intended to cause unnecessary delay within the meaning of L.C. §5813 and Board Rule §10561. The Board, after reviewing the case concluded: (1) that a petition for reconsideration is a pleading, petition or legal document within the meaning of Board Rule §10561; (2) that the filing of a petition for reconsideration is a sanctionable bad faith action or tactic if the filing is done for an improper motive or is indisputably without merit with no reasonable justification including (but not limited to) a clear failure to meet the jurisdictional statutory deadlines for filing a petition for reconsideration; (3) that, on the present record, it appears that Valley Subrogation's act of filing a petition for reconsideration six months after the October 6, 1999 Findings and Award order of the WCJ was indisputably without merit and without reasonable justification; and (4) that, therefore, the Board will issue a notice of intention to award sanctions of $300.00 against Valley Subrogation, together with reasonable attorney's fees and costs payable to the defendant for responding to Valley Subrogation's petition for reconsideration.

La Mirada served the Board with notice that it was representing Valley Subrogation. The matter then came to trial on all issues including La Mirada's lien. A hearing representative employed by La Mirada appeared at the hearing.

At the trial, applicant and defendant entered into stipulations, which, among other things, provided that defendant, would pay, adjust or litigate various liens, including La Mirada.

The matter was then continued for a lien trial. La Mirada then appeared for the lien trial. At the lien trial the matter was continued to a new trial date. The Board served notice of the lien trial on La Mirada. Defendant served notice of the lien trial on La Mirada and also on Valley Subrogation. Neither La Mirada nor Valley Subrogation appeared at the trial. The WCJ issued a notice stating that La Mirada's lien was being disallowed unless it filed a written objection within 15 days showing good cause. Valley Subrogation filed a letter objecting to the notice of intention to disallow La Mirada's lien. The WCJ issued an order rescinding the notice of intention. The matter was set for another trial on La Mirada's lien. The Board's file reflects the order was served by mail on La Mirada, but not on Valley Subrogation. The Board issued a second notice that the matter had been set for lien trial. The notice reflects that La Mirada was served, but not Valley Subrogation.

The matter was set for lien trial and defendant appeared, but neither La Mirada nor Valley Subrogation appeared. The WCJ issued a notice that the issue of La Mirada's lien claim would be submitted for decision on the record, absent of showing good cause to the contrary in 15 days. The notice of intention stated that any objection must address not only the merits, but repeated failures of La Mirada to appear for trials. The notice of intention was served on La Mirada and Valley Subrogation. The mailing to Valley Subrogation was returned with a notice that the correspondence was not deliverable as addressed and the post office was unable to forward. No opposition was received to the notice of intention. An order issued disallowing La Mirada's lien. The Findings and Order issued on October 6, 1999.

On October 20, 1999, Kurt Flanagan of Valley Subrogation executed a request to review the WCAB file. There is no indication in the Board's record that the request was denied or not acted upon. On April 12, 2000, over six months after the WCJ's Findings and Order, Valley Subrogation, on behalf of La Mirada, filed a petition for reconsideration. The defendant filed an answer to the petition for reconsideration. On May 30, 2000, the Board issued an Opinion and Order Dismissing Petition for Reconsideration and Granting Removal on Board Motion. In that decision, the Board observed, that ordinarily the party has 25 days within which to file a petition for reconsideration from a final decision that has been served by mail on an address in California. This timely filing requirement is jurisdictional. Where, however, the Board's service of its decision is defective, the statutory time period for filing a petition for reconsideration does not begin to run until the decision is actually received. The Board concluded that the service in October 1999 was not defective. The Board's record established that the decision was timely served by mail on La Mirada itself. Although the Board will also ordinarily serve a decision on the attorney or agent of a represented party or lien claimant, Valley Subrogation was not served with the decision only because, when the Board had served the notice of intention to submit upon them, the notice of intent was returned as an undeliverable. Thus Valley Subrogation was not served with the decision because it had breached its duty to apprise the Board of its correct address in accordance with Rule §10396.

The Board observed that even if the service of the order in October was somehow defective, the reconsideration was still untimely since Valley Subrogation had made a request to review the Board's file just 14 days after the decision. Under Rule §10753 and other provisions of law, the lien claimant had the right to inspect the Board's file and there was no indication in the Board's file that this request was denied and not acted on. Accordingly, the Board inferred that Mr. Flanagan's request was honored and that he reviewed the Board's file. Therefore, the Board concluded that La Mirada's representative gained personal knowledge of the decision in October 1999 and did not file a petition for reconsideration until October 12.

The Board then dismissed the petition for reconsideration as untimely. The Board concluded that, based on their review of the record, that La Mirada's petition for reconsideration may have been the result of bad-faith actions or tactics that are frivolous or solely intended to cause unnecessary delay within the meaning of L. C. §5813 and Board Rule §10561. Therefore, in accordance with the L. C. §5310, the Board removed the matter to itself to consider sanctions.

The Board, after considering sanctions, concluded that under the facts of this case that a petition for reconsideration is a pleading or legal document, that the filing of a petition for reconsideration is a sanctionable bad-faith action or tactic if the filing is done for an improper motive or indisputably without merit and with no reasonable justification, including, but not limited to, clear failure to meet the jurisdictional statutory deadlines for filing a petition for reconsideration.

On the present record it appeared that Valley Subrogation's act of filing a petition for reconsideration six months after the Findings and Order was without merit and was reasonably without justification. Therefore, the Board issued a notice of intention to allow a sanction of $300.00, together with reasonable attorney fees and costs payable to defendant. The Board further concluded that, while here they are noticing their intention to award sanctions based on an egregiously untimely petition for reconsideration (filed without providing any significant explanation why its lateness might have been justified), they observed that sanctions may also be proper for a timely petition, if it is indisputably without merit under the circumstances of the particular case.

The Board went on to state that, although they were issuing a notice of intent to award sanctions under the particular circumstances of this case, they emphasized their action does not constitute an open invitation for parties to request sanctions in every matter pending before the Board on reconsideration, removal or disqualification. Indeed, a request for sanctions that fails to clearly and specifically articulate reasonable justification for the request may itself be sanctionable. The Board then issued its notice of intention to allow the sanctions.

The lien claim representative, Valley Subrogation, responded to the Board's Notice of Intention to Impose Sanctions. The response was late, but the Board accepted the excuse for the tardy response.

In the response, the lien claim representative acknowledged that its dilatory actions and lateness in filing the Petition for Reconsideration were inappropriate. They explained that they were merely attempting to represent the client in an attempt to collect expenses believed to be owed by the defendants. They also argued that, rather than issuing the October 6, 1999 decision, the WCJ could have or should have issued a Notice of Intention to Submit this matter for decision. They offered no reason whatsoever for their failure to file the Petition for Reconsideration in a timely manner.

Because the lien claim representative failed utterly to explain why its Petition for Reconsideration was egregiously untimely, the Board awarded sanctions against them. There was one dissenting opinion, which concluded that the lien claim representative did provide reasonable justification for their actions, and therefore L. C. §5813 was inapplicable.

9. *Kamel v. Westcliff Medical, Superior National Insurance Company,* (2001) LBO 301852 (Appeals Board en banc).

Applicant sustained an industrial injury. A Findings and Award issued on February 2, 2000 where it was determined, among other things, that the injury caused permanent disability of 48 percent. The defendant delayed payment of permanent disability awarded per the Findings and Award. A check issued on February 21, 2001, and defendants' next check was not issued until March 28, 2001. The matter was set for trial on the issue of penalty.

At the trial the applicant was the only witness. The applicant indicated that he called the insurer on either the 25th or 26th of March because he had not received the check for permanent disability indemnity following the one dated February 21, 2001. The applicant stated that he spoke to a Mr. Louth, who told him the checks would be sent very soon and thereafter the checks would be on time. No mention was made, however, of what caused the delay.

Applicant received the next check, which included the amount past due and the 10 percent increase pursuant to L.C. §4650(d) two days after the conversation with Mr. Louth. The WCJ, following the hearing, issued a Findings and Order that defendant had unreasonably delayed the payment of permanent disability and assessed a 10 percent penalty against the entire amount of those benefits pursuant to L.C. §5814. Defendants timely filed a petition for reconsideration.

Defendants presented no evidence whatsoever with respect to delay in the case. Defendants' petition for reconsideration was based on the argument that the burden of proof was on the applicant to prove there was an unreasonable delay.

The WCAB indicated that for 30 years it has been held that the language of L.C. §5814 contemplates that when an injured worker has shown a delay in the payment of compensation, the burden is on the employer to show good cause for the delay, *Kerley v. WCAB* (1971) 36 CCC 152. The Board indicated the only satisfactory excuse for delay in payment of disability benefits, whether prior to or subsequent to award, is a genuine doubt from a medical or legal standpoint as to liability for benefits and the burden is on the employer or carrier to present substantial evidence upon which a finding of such doubt may be based.

The Board indicated none of the cases cited by defendant, including the recent Supreme Court case *of State Compensation Insurance Fund v. WCAB (Stewart*) (1998) 63 CCC 916, provides support for overturning the longstanding precedent

by changing who has the burden of proof on the reasonableness of delay in the payment of compensation under L.C. §5814.

The Board indicated that *Stewart* did distinguish the language in *Kerley* with respect to what constituted the only satisfactory excuse for delay in the payment of disability benefits. The Stewart case and the case of *County of Sacramento v. WCAB (Souza*) (1999) 64 CCC 30 provided an exception to *Kerley* in the case of an inadvertent clerical error caused by a brief delay in the payment of benefits. Once the applicant has shown a delay under *Stewart* and *Souza*, the employer then has the burden of showing that the delay meets the standard of those two cases for an exception to the *Kerley* rationale.

The Board stated that they could find no legal authority to support defendants' proposition that they may delay the payment of compensation benefits and present no evidence whatsoever as to the reason for the delay, but escape the penalty because applicant failed to prove the delay was unreasonable. The Board went on to state it is well-established case law regarding who has the burden of proof as to the reasonableness of delay under L.C. §5814. Common sense and fairness dictate that the party responsible for the delay shall have that burden.

In this case the defendant chose not to present any evidence with respect to its delay of permanent disability benefits and after an adverse decision improperly attempted to shift the burden to applicant as to the reasonableness of the delay.

The Board reiterated that in penalty cases the burden is on the applicant to show a delay, and once that has occurred, the burden shifts to the defendant to show that the basis for the delay was reasonable.

The award of penalty was affirmed.

10. *Pacific Bell v. WCAB (Russell)* (2001) 66 CCC 832.

Here the defendant sought review of a decision after reconsideration from the WCAB regarding the award of a 10% penalty under Labor Code §5814. The Board issued a finding as follows: "Pacific Bell unreasonably delayed payment of death benefits to the applicant widow, for which a 10% penalty in the sum of $7,000.00 is payable to the applicant." The defendant, herein, contends that the decision after reconsideration does not comply with L. C. §5908.5 because the Board fails to state the evidence relied upon and specify in detail the reasons for the penalty assessment. The Court agreed, finding no judicial explanation whatsoever. The award was annulled and the matter returned to the Board for redetermination of the penalty issue.

It is undisputed that the applicant is entitled to the statutory death benefit in the amount of $70,000.00 payable at $224.00 per week. The worker died May 30, 1997. On December 11, 1998 the WCJ issued a supplemental findings and award

in which he denied the defendant credit under L. C. §4909 for payments made to the applicant under a pension plan as against the death benefit. The WCJ also found that the defendant unreasonably delayed payment of the death benefit. The WCJ determined that the benefit was due on September 1, 1998, but was not paid until September 17, 1998, which he found to be unreasonable.

The Board granted reconsideration, rescinded the WCJ's supplemental findings and award to take additional evidence on the credit issue. The Board did not rescind the finding of penalty.

After remand the WCJ reissued his award, finding that the defendant was not entitled to credit and finding the penalty for delay in payment of the death benefit. The WCJ also assessed an additional 10% penalty because the Board had not disagreed with his analysis.

On November 21, 2000 the Board granted reconsideration, rescinding the second penalty Award. The Board noted that their rescission of the supplemental findings and award suspended all findings including the penalty imposed for delay in payment of the death benefit. The defendant was under no obligation to make payments while a findings and award is suspended. After the matter was remanded to the WCJ, he could have made a different finding on the penalty issue, and the defendant could have reasonable doubt from a legal standpoint as to its liability to pay the penalty.

On January 3, 2001, the defendant filed a petition for writ of review with the Court of Appeals. The Court pointed out that under *Bracken v. WCAB* (1989) 54 CCC 349, it has the power to review the decisions of the Board, and it is not bound to accept the Board's factual findings under certain circumstances.

The Court pointed out the Board is mandated to comply with L.C. §5908.5 and provide a basis for its opinion by stating the evidence relied upon and specify in detail the reasons for their opinion, citing *Goytia v. WCAB* (1970) 35 CCC 27. Here the Board failed to provide any explanation for the first penalty award. Such omission precludes meaningful review and is inherently prejudicial to the defendant.

The award of penalty was annulled, and the matter was returned to the Board to review the matter and determine if a penalty should he imposed under L. C. §5814.

11. *Schroeder v. WCAB* (2001) 66 CCC 837.

The applicant sustained an industrial back injury and in April 2000 was awarded temporary disability indemnity, permanent disability indemnity of 67%, future medical treatment, attorney's fees and two penalties against T.D. and P.D. under L.C. § 5814. The T.D. and P.D. penalties were paid 35 days later, and the

attorney's fee was paid 45 days later. The defendant did not include applicable interest.

The applicant sought multiple penalties, but the WCJ awarded only one penalty, holding that the delays amounted to a single course of conduct by the defendant. The WCJ rejected the defendant's contention that the payment of interest was offset by the defendant's overpayment of P.D. The single penalty finding was awarded only against T.D.

The applicant sought reconsideration, and, in his Report and Recommendation on Reconsideration, the WCJ said that the award of a single penalty for one continuous act of misconduct struck a fair balance between the applicant's right to prompt payment and avoidance of overly harsh results.

A Board panel adopted the WCJ's report. The applicant sought review, claiming six separate penalties.

The Court of Appeal granted review. The Court relied upon *Gallamore v. WCAB*(1979) 44 CCC 321 and *Rhiner v. WCAB* (1993) 58 CCC 172, which held that both pre-award and post-award delays are subject to penalty, the penalty is mandatory whether or not the amount is de minimus, multiple penalties are imposed for separate acts of delay or nonpayment, and the penalty is imposed against the full amount of the class of benefits delayed. T.D., P.D., and attorney's fees are separate classes of benefits, and, therefore, the Board erred by assessing only a penalty against T.D. where P.D. and attorney's fees were also delayed. Once a delay is found, the Board has no discretion in calculating the penalty. The failure to pay the award and failure to pay the interest thereon was deemed a single course of conduct justifying a single penalty.

The Court annulled the WCAB decision and awarded three penalties, one on T.D., one on P.D. and one on attorney's fees.

12 *Stock v. Hartford Acc. & Indemnity Company* (2001) 29 CWCR 77.

A Board panel granted reconsideration of a WCJ's award that made no provision for reimbursing the applicant for the costs of a report and testimony of an independent disability evaluation specialist produced to rebut a recommended rating, and it awarded the costs of the report and testimony. The Panel ruled that when the applicant placed the bills of the independent disability evaluation specialist in evidence, the act can impliedly raise the issue of the litigation costs.

The WCJ, after the hearing, issued a recommended permanent disability rating, which was done by a Disability Evaluation Specialist employed by the Division of Workers' Compensation. The Disability Evaluation Specialist found that no rating was scheduled or recommended for the disability described. Applicant objected and requested a hearing to cross-examine the Disability Evaluation Specialist. At a

hearing the Disability Evaluation Specialist was cross-examined and the applicant produced the testimony of Margaret Easton, an Independent Disability Evaluation Specialist. The minutes of hearing do not indicate whether the applicant expressly raised litigation expense as an issue, but he did place in evidence the bills from Easton for her services. The WCJ, relying on Easton's testimony, found the injury caused a 16% permanent disability. The award made no provision for reimbursing applicant for the expenses of the Specialist's testimony.

A petition for reconsideration was filed. The petition argued the expenses were a proper item of cost, and although the minutes did not show that the issue was expressly raised, it was clearly raised by implication when the bills were offered into evidence. The WCJ, in his report on reconsideration, said he did not consider the cost because it was not raised at trial. A Panel reversed, finding that the issue was not raised at the mandatory settlement conference, or trial, because it was not relevant until applicant objected to the recommended rating. At the hearing to cross-examine the Disability Evaluation Specialist, applicant not only placed the bills and written report into evidence, but also produced the testimony of the expert. The WCJ relied on the opinion of the expert as being the better reasoned and more persuasive. The reasonable inference to be drawn from this is that the applicant raised the issue of costs under L.C. §5811 for the testimony of the expert witness. The Panel granted reconsideration and amended the findings and award to cover reimbursement for the cost of the Disability Evaluation Specialist's services in an amount to be adjusted by the parties.

XXIX Attorneys fees

1. *Curran v. Pacific Telesis Group* (2001)29 CWCR 254 (Board Panel Decision).

Applicant sustained multiple injuries in a fall. After a hearing at which applicant was represented by a lay hearing representative, the workers' compensation judge found permanent disability of 49 percent and allowed an 11 percent fee. Defendants sought reconsideration, contending the PD was not justified by the evidence and the fee was excessive for a nonattorney. The WCAB denied reconsideration.

Defendants then filed for a writ of review, repeating the arguments they made before the Board and adding the issue that if the defendant had no standing to attack the amount of the representative's fee, the Board should have questioned it on its own motion. The Court of Appeal denied the petition without opinion, and, finding no reasonable basis for the petition, remanded the case to the Board to make a supplemental award of a fee for services rendered.

The applicant's attorney filed a petition for costs and services. The petition asked for four hours for Attorney one at $250 an hour and six hours for Attorney two at $225 an hour and ten hours for the hearing rep at $125 an hour. They also asked

for $67.58 for printing and mailing the Answer, and $750 for typing the Answer. A Board panel, citing *99¢ Only Stores v. WCAB* (2001) 65 CCC 456, indicated that different levels of fees can be justified depending on the experience and qualifications of the person performing the services.

The attorneys had been practicing before the WCAB for approximately 10 years, but there was no evidence of their comprehensive appellate experience or expertise. Based on comparison with cases involving comparatively experienced attorneys, an hourly rate of $200 was reasonable. The $200 benchmark is fair and appropriate in the absence of a showing of unique experience or extraordinary accomplishment.

Applying the same reasoning to the services of the hearing rep, the panel found the requested $125 to be reasonable, given the quality of the Answer. The hearing rep was a law school graduate, not only with 23 years' experience in labor and employment law, but also 10 years in workers' compensation. The hearing rep had previously been allowed fees based on the same rate deemed reasonable for a nonattorney being supervised by an attorney.

Next turning to the 20 hours claim, the panel observed that the Answer contained virtually all new material and responded to every argument, including the somewhat novel ones made by the defendant in its petition for writ of review. 20 hours of work to produce that product was reasonable, and there was no evidence to the contrary.

Finally, the panel found the costs claimed for printing and mailing the Answer to be reasonable, but said the expense of typing the Answer was not reimbursable because it is part of the overhead compensated in the hourly rate set for attorneys. Accordingly, the panel made an additional award against defendant of $3,250 in appellate fees and $67.58 in costs.

2. *Draper v. Aceto* (2001) 66 CCC 1297.

The applicant was injured in an on-the-job automobile accident. The self-insured employer provided more than $18,000 in workers' compensation benefits. The injured worker retained counsel and sued two third parties, the driver and the owner of the other vehicle. The employer also sued the third parties. The lawsuits were consolidated. The matters were settled for the policy limit of $15,000 which was placed in trust pending a determination as to how it was to be dispersed. The applicant's third party attorney demanded one-third of the settlement amount as his fee. The superior court judge denied the fee request and the attorney appealed. The appeals court affirmed the denial of the attorney fee request on the theory that since the applicant got no recovery, then the attorney should likewise get none. The contingency was with the employee, not with the employer. Therefore, the contingency simply did not occur.

The attorney appealed to the California Supreme Court which granted review. The Court cited L.C. §3860(e) which states that if attorneys separately representing the employer and the employee are both active in procuring a settlement, then each attorney's fee is calculated by reference to the benefit achieved for the attorney's own client. If the client is the employee and the employee recovers nothing because the settlement proceeds are less than the employer's reimbursable compensation costs, then the employee's attorney cannot recover fees from the settlement proceeds. The Court found no unfairness here where the injured worker obtained no recovery and the employer got no free ride because they had to pay their attorney. Justices George and Werdegar dissented.

XXX Civil Actions

State Compensation Ins. Fund v. Superior Court (Schaefer Ambulance Service, Inc.) (2001) 66 CCC 16.

An employer insured by State Fund filed a class action complaint alleging a breach of the implied covenant of good faith and fair dealing and alleging negligence. Plaintiffs claimed they were typical members of an ascertainable class who purchased workers' compensation liability insurance during calendar years 1984 through 1992 under a policy which provided that all premiums would be determined by the Workers' Compensation Insurance Rating Bureau's manuals of rules, rates, rating plans and classifications. The plaintiff employer/insureds alleged State Fund had misallocated and misreported their financial information to the Rating Bureau, including information concerning the experience modification factor.

The experience modification factor includes financial information reported in the indemnity and medical expense columns, but not in the defense expense columns. Plaintiffs complained that State Fund either intentionally or negligently misreported medical-legal reports requested by the employer or insurer in the medical expense column rather than the defense expense column. This increased the experience modification factor, and in turn increased the insurance premium. The plaintiffs further alleged that State Fund violated the implied covenant of good faith and fair dealing by refusing to provide access to all individual claims files to its insureds and by refusing to provide the insureds with the ability to audit or monitor the manner in which State Fund represented the insureds in various workers' compensation actions.

State Fund moved for summary judgment, and the civil action was stayed for several years while the plaintiffs pursued their administrative remedies. In 1994, the WCIRB determined that State Fund had improperly reported the defense medical-legal expenses as incurred medical and not incurred defense expense. Following final appeals of that administrative ruling, the civil action stay was lifted.

State Fund's subsequent motion for judgment on the pleadings was denied through the trial and intermediate appellate level. State Fund alleged the action was barred by Insurance Code § 11758, which provides in part that no act done pursuant to the authority conferred by the Insurance Code sections regarding the rating organization shall constitute a violation of, or grounds for, civil proceedings under any other law of California which does not specifically refer to insurance. State Fund's essential contention was that its misreporting of medical expense was statutorily immune from civil prosecution. The Supreme Court noted that what is authorized by the general article covering ratemaking is cooperation between insurers, ratings organizations and advisory organizations in rate making. The antitrust laws would otherwise bar this type of price setting activity. The plaintiffs made no such contention of antitrust violation and did not challenge the manner in which the Rating Bureau sets premiums or rates. The plaintiff's allegations dealt solely with misreporting and misallocation of expense. The Supreme Court analyzed the purpose of §11758's immunities and indicated that it was doubtful the section was intended to paint with so broad a brush that it would insulate a single carrier from liability for misreporting and misallocating expenses.

The Supreme Court noted that the administrative proceedings found malfeasance at every level. The premium the plaintiffs should have been charged was capable of calculation by experts in a civil trial court. The Supreme Court rejected State Fund's claim that the matter fell within the scope of the exclusive remedy provisions of workers' compensation. The dispute was between an insured employer and its insurer, and while it arose in the context of workers' compensation, the practical effect was no different from any other insurance dispute. The court made no conclusion as to whether the cause of action stated by the plaintiffs was valid but did determine that the civil suit was not precluded by §11758's immunity.